"THE PROBLEM AND POSSIBILITIES OF ACTIVE EUTHANASIA IN THE CLINICAL NURSING SETTING: SOME EDUCATIONAL ISSUES."

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ABSTRACT

Although death is an inevitable consequence of life, the exact time of death has come increasingly under human control. It is now possible to prolong human life beyond the point at which some patients actually want to go on living. It is becoming increasingly difficult to determine the point at which a "gentle and easy" death can be achieved. Many nurses now argue that the time has come to question whether life should be preserved in every case where it is technically possible to do so, regardless of the quality of that existence.

This study researches one of the fiercest on-going debates within the area of health-care. That is, the question as to whether the option to use active euthanasia to end a patient`s suffering could ever be justified within the clinical nursing setting, where the main role of the nurse has been generally accepted to be one of maintaining and supporting all human life.

In order to consider the problem and possibilities of euthanasia in the clinical nursing setting, and the educational issues involved, this study examines a broad selection of international literature and research papers, from both primary and secondary sources. Particular emphasis is placed upon the studies carried out in Holland - where euthanasia is accepted, provided it is carried out within certain guidelines - and Australia, whose Northern Territories have now legalised active euthanasia.

The findings of this research indicate that active euthanasia may not prove to be the straightforward option that many people believe it to be. Every case is different. therefore, every individual case needs to be evaulated individually. Nurses have a responsibility to respect the feelings of those who would wish to end their lives in this way. However, they also have a responsibility to ensure that they will always be able protect the interests of those who would not, especially those who are unable to speak for themselves.

The study concludes that British nurses need time to become more familiar with the ethical and legal issues surrounding euthanasia and discover, if legalised, where their professional responsibilities would begin and end. It recommends that a full evaluation must also be made of the possible effects of the Australian legislation and the Dutch experience. It concludes that it is also important to examine alternative options, before such an important (and probably irreversible) moral leap is taken, so that we are sure it is the only way forward.

DECLARATION

"THIS WORK IS ORIGINAL AND

HAS NOT BEEN SUBMITTED IN SUPPORT OF

ANY DEGREE QUALIFICATION

OR COURSE."

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LIST OF ABREVIATIONS

BBC	British Broadcasting Corporation.
BMA	British Medical Association.
CH	Chapter.
ENB	English National Board.
GMC	General Medical Council.
n	Number.
PREP	Post-Registration Education and Practice.
PVS	Persistent Vegetative State.
QALY	Quality Adjusted Life Years.
RCN	Royal College of Nursing.
TV	Television.
UKCC	United Kingdom Central Council.
USA	United States of America.
VES	Voluntary Euthanasia Society.

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CHAPTER 1

INTRODUCTION

> Every day, rational people all over the world plead to be allowed to die.....
> Some of them are dying already... .
> Some of them want to die because they are unwilling to live the only way left open to them.....
> Sometimes they plead for others to kill them....
> (Dworkin, 1993, p.179)

In thirty years of clinical nursing practice I have often cared for people who have reached a point where they have decided that "enough is enough" and have welcomed (even requested) death. In the earlier years, (particularly on the "geriatric" wards) the decision about how, when and where an individual patient died was often made solely by health-professionals, without any reference to the patient.

Today, however, there are an ever-increasing number of individuals demanding the right to make fully-informed choices concerning their own health-care needs, including the "right to die". As a primary nurse I believe that I have a duty to respect the decisions made by those in my care. Yet, in the role of patient-advocate, I also believe that I have a duty to protect the

interests of those vulnerable patients who are unable to make such decisions for themselves. This responsibility is both ethical and legal.

I believe that there is no contemporary health-care issue that reflects this dichotomy more closely than the issue of active euthanasia. Furthermore, there is no area of clinical practice where it is more relevant for nurses to research both the problems and possibilities of active euthanasia than "care of the elderly". Yet, to date, little research has been undertaken.

That is why, in 1994, I decided to conduct my own survey examining the attitudes towards euthanasia amongst nurses working in a variety of clinical settings. The findings reflected, not only a high level of passivity about the issue but also, in many cases, a complete lack of understanding about what actually constitutes an act of euthanasia. I had assumed initially that these findings, to some extent at least, had been due to the way in which my particular research was carried out. Yet, the following year, a national survey carried out by Mr. Reg. Pyne - former senior member of the UKCC - achieved similar results. (Pyne, 1995, pp. 36-38)

These findings are particularly worrying as members of the British public increase their call for "the right to die". Voluntary active euthanasia has already been legalised in the Northern Territories of Australia. In Holland, although it has not yet been legalised, doctors who carry it out will not face prosecution providing they act within certain guidelines. My personal concern is that unless the issue of euthanasia is given a full consideration by nurses now we may reach a point, in the not too distant future, where this public demand may be met before the nursing profession has the opportunity to examine all the possible implications, or the alternative options.

Through this research, I examine the problem and possibilities of active euthanasia in the clinical nursing setting, with particular reference to the elderly in our society. I also consider the issue from an educational perspective and attempt to discover how long it will take for nurse-education to provide every nurse with the resources (both theoretical and experiential) s/he needs in order to be an effective ethical decision-maker.

In order to obtain a full understanding of the problem and possibilities of active euthanasia in the clinical nursing setting,

and the educational issues involved, it is necessary to begin, in in the next chapter, by considering the contemporary issues surrounding the euthanasia debate that are particularly relevant to the clinical nursing setting. Chapter three goes on to examine the debate from an historical perspective. This is important for two reasons. Firstly, the actual meaning of the term euthanasia has actually changed over time. Secondly, many of the present-day perspectives - such as the Christian perspective - are derived from beliefs and attitudes that have been preserved from earlier periods in human history.

These perspectives underlie many of the present ethical and legal stances that have been taken on the subject, which are further discussed in chapters four and five. Chapter four considers the ethical issues that underlie the decision-making process within clinical nursing. Chapter five considers the law in relation to nursing practice and the possible implications of the legalisation of active euthanasia. After all, it is in the realm of ethics and law that many of the problems associated with active euthanasia are being considered.

Having examined the debate surrounding active euthanasia from ethical and legal perspectives, it is then necessary to move

on, in chapter six, to evaluate whether (or not) the introduction of the "advanced directive" (or "living will") can resolve some of the problems that are related to the potential legalisation of active euthanasia. It is also important, in the following chapter, to examine the credibility of the "slippery slope" argument. This argument implies that the introduction of <u>any</u> legislation relating to voluntary active euthanasia in the clinical nursing setting, would eventually lead to the introduction of involuntary active euthanasia.

Chapter eight goes on to consider the ways in which the role of the nurse has changed, and extended, over time. The role of the nurse is becoming increasingly that of an autonomous professional, and thus, we have an increasing legal responsibility towards those in our care. Now, more than ever before, we are required to be ethical decision-makers. Therefore, the extent to which our personal belief system and nurse-education system determine the way in which we evaluate these dilemmas and issues must also be fully considered.

There can be little doubt that the legalisation of active euthanasia would have a far-reaching effect upon the nursing profession. Chapter nine considers some of the relevant

educational issues that would necessarily arise out of such a major change in nursing practice. Education, both basic and post-registration, is vital to the continued development of the nursing profession. The introduction of active euthanasia might effect the way in which the role of the nurse is perceived by those entering the profession and the patients in our care. Therefore, we must consider whether it would be professionally acceptable for procedures associated with the ending of a life to become assimilated with the role of "carer". Furthermore, as nurse-education, and professional socialisation, determine the way in which nurses fulfil their role, it is necessary to consider the possible effects that the changes in nurse-education, associated with Project 2000 and PREP, might bring in relation to the possibility of active euthanasia being legalised.

However, before we can fully consider and evaluate the more problematic aspects associated with active euthanasia in the clinical nursing setting - and the credibility of the arguments put forward in favour and against its legalisation - it is necessary to undertake a full examination of all the issues surrounding the contemporary debate on active euthanasia.

CHAPTER 2.

ACTIVE EUTHANASIA:

THE ISSUES.

Death may be regarded as a natural process, in that, dying is an experience that each human being shares with the rest of created life. Yet, human beings are unique because, they alone, are able to contemplate their own dying and attempt to understand both its nature and significance. (Wilkinson, 1988, p.274) Although death can be seen as being inevitable, the exact time of death has come increasingly under human control. The technology is now available to forestall natural death by many novel and revolutionary methods; not only to resuscitate individuals who are dying, but also to maintain human life by the use of sophisticated machinery and drug therapy.

Despite the many benefits that have come with this modern technological society, it has not, for the most part, been able to eradicate human suffering at the point of death. In fact, in many ways it only appears to have exacerbated it. The improvements in public health and medical technology have sometimes enabled us to prolong life beyond the point at which

individuals actually want to go on living. All too often, not least because there is no legal support for any alternative, we hear of cases where the terminally ill feel that they have had to suffer the needless pain of being kept alive without any real hope. They have also had to endure the "pain" of subjecting their families to a harrowing "death watch". (Shapiro,1994, p.34) This dilemma has led some to suggest that today, more than ever, "it is not death itself that we fear, it is the process of our dying" (Haselden, 1993, comment) We are afraid, not only of the pain, degradation and loss of self-command that can be associated with a protracted death, but also, of becoming a burden to (or being rejected by) those who care for us.

At some given point in time, every human life must come to an end. Given the choice, there are few individuals who would actively choose to suffer, either a prolonged and painful death or, the perceived "indignity" of surviving indefinitely in a persistent vegetative state. At the time of death we need to know that we can be sure of the comforting presence of those we love. We also need to be confident that our pain and suffering will be relieved, our humanity will still be respected, and our final wishes complied with. If this is accepted, can there be any argument for keeping people alive against their will, once

there is no chance of recovery, or to have lives that are incompatible with human dignity?

This increasing ability to maintain human life poses many difficult problems concerning the medical, legal and ethical criteria by which such therapy can, (or should), either be maintained or discontinued. Many physicians and nurses are becoming disturbed by the degree to which technological solutions influence care during the final days of a terminal illness. They are also concerned about the undertreatment of pain. (Soloman et al, 1993, p.14) Evidence, such as that collected by the "Working Party on Euthanasia and Clinical Practice", (1982) increasingly suggests that some nurses and doctors are already treating their patients in ways that are intended to hasten the moment of death. Whilst some regard such practices as being acceptable from an ethical perspective, (even though they are illegal) others suggest that they have a corrupting effect upon clinical practice. (Linacre Centre, 1982, p.1)

Thus, one of the fiercest on-going debates within the area of health care is the question as to whether the option to use active euthanasia to end an individual`s suffering could <u>ever</u> be

justified, either on medical, ethical or legal grounds. Can it ever be considered a realistic option in the clinical nursing setting, where the main role has always been generally accepted to be one of supporting and maintaining human life. Many nurses now argue that the time has come to question as to whether life should be preserved in every case where it is technically possible to do so, regardless of the quality of the existence they are attempting to preserve. Some feel that human dignity demands that, for each individual, there is a time to die. The "right to life must include the right to let go" because of the distinction between that which can be described as a basic biological life and the quality of life that is associated with being human. (Poole, 1993, pp.26-29)

The kind of medical progress that has led to an increase in the human lifespan beyond the biblical three-score-years-and-ten, has also raised many philosophical issues. This has led to an increase in public debate and concern about active euthanasia. It has also led to an increasing pressure for its legalisation, particularly in the light of recent cases in the media. The Northern Territory of Australia has, in 1995, become the first jurisdiction that permits a doctor to end the lives of those who are terminally ill and who express a wish

to die. (Cole-Adams, 1995, p.37) The possibility that active euthanasia might, at some point in the future, become legalised in this country is now an important issue within the nursing profession because nurses in the clinical setting will inevitably become personally involved at what has been described as the "sharp end" of these life and death decisions. (Autton, 1984, p2)

At the beginning of my own nursing career, thirty years ago, the definition of clinical nursing practice was that presented by Virginia Henderson to the International Council of Nurses. ie;

> to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.
>
> (Henderson, 1961, cited in Curtain and Flaherty, 1982 , p.70)

Whilst this definition still applies today, not only has the body of theoretical knowledge underpinning nursing practice expanded but, within society, there has been a growing awarness of individual health-care requirements. Therefore, the responsibilities that come with the role of the nurse are considerably increased. The goal of nursing today encompasses the holistic care of the individual throughout the lifespan, in a

variety of settings, rather than solely being restricted to illness care within the confines of the hospital. As a result, nurses are now required to face many complex ethical issues on a regular basis. They are also becoming more accountable for the far-reaching decisions made concerning those within their care.

Nurse-education has also changed in response to the changing demands placed upon the role of the nurse within society, and nurse-education programmes are designed to reflect these professional demands. Increased autonomy within the profession has replaced the role of "hand-maid" with that of independent practitioner. Today, more than ever, nurses need to be well educated in both general and specific ways, in order to be able to think and reason accurately about the issues for which they are becoming increasingly accountable within the legal process. (Curtain and Flaherty, 1982 p.70-73)

The complacancy that can be seen to exist within the nursing profession today, concerning active euthanasia, can be clearly seen in the fact that of the many thousands of nurses who subscribe to the Nursing Times, only 149 were prepared to return a questionnaire about their views on euthanasia. (Pyne, 1995, p.36) Should active euthanasia become legalised in this

country, (even though nurses may not be solely responsible for making the final decision concerning their patients, nor actually administer the drug themselves), "nurses` close relationship with the patient means they are likely to play a key role in euthanasia". (Sheldon, 1993, p.15) Nurses, therefore, need to make a full evaluation of the issues surrounding active euthanasia and the ways in which its introduction might affect, not only their own clinical practice, but also, the training of the next generation.

The word "euthanasia" literally means "a good/gentle/easy death". However, in recent times, it has come to be known by the more precise definition of to "kill someone where, on account of a distressing physical or mental state, this is thought to be in his own interests." (Seedhouse and Lovett, 1992, p.49) Thus, whilst euthanasia literally means death without suffering, it has now come to be more generally accepted as "mercy killing." Euthanasia has a long history. In early times, doctors were seldom, if ever, involved in the care of the dying. However, as long ago as the early Roman Empire, some doctors may have given a cocktail of lethal drugs to assist those individuals who wished to die because of mental distress or incurable disease. It is thought that, in order to avoid any charges of murder,

these doctors seldom administered these drugs by their own hand. By the end of the Elizabethan era, doctors had established a more definite role in the care of the dying. At this time, Francis Bacon is quoted as having said that a physician`s office was:-

> not only to restore health, but to mitigate pain and dolors, and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage.
> (Trowell, 1973, p.12)

An individual`s life may be terminated, or death accelerated, either actively or passively. The term "passive" euthanasia can be defined as the withdrawal or withholding of certain medical treatment intended to maintain the lives of the incurably sick. In the USA, passive euthanasia has already become morally acceptable. To date, the American courts have consistently upheld individuals` decisions to be removed from a ventilator, or refuse tube feeding. In this country, the decision to remove the feeding tube of "Hillsborough victim", Tony Bland, was also upheld by the courts.

One survey found that, even amongst Christian clergy, over 77% agreed that becoming dependent upon machinery for life was worse than dying. There was also a definite ranking, in

order of priority, of the different circumstances in which passive euthanasia might be a more acceptable alternative. The decision to forgo any medical feeding, in the case of Tony Bland was in keeping with the tradition of Roman Catholic moral theology. (Kelly, 1993, p. 1539)

It is not a medical duty to maintain the life of a patient by technological means. However, the active "putting to death" of a person who is old and sick, or dying, is a completely different matter, even if it is done at the specific and sincere request of a rational patient. For example, Dworkin, (1993, pp.184-186) cites the case of Dr. Nigel Cox, who administered a lethal dose of potassium chloride to his patient. Dr. Cox argued that, because of protracted pain that could not be relieved by drug therapy, life had become intolerable for Lillian Boyes and she begged him to end her suffering. Even though the judge accepted his compassionate motives, Dr. Cox was convicted of attempted murder.

Research findings show that, even in cases of severe distress, for most physicians the actions taken by Dr. Cox would not be viewed as acceptable medical practice. For example, 98% of physicians questioned would agree not to intubate in

order to maintain life. A futher 86% would agree to give a drug dose that might cause respiratory compromise in order to relieve pain, and 59% would agree to turn off a respirator. Yet, only 1% would agree to give a lethal injection, (even if it was at their patients express request), because they felt that, in these circumstances, they would be "killing" the patient. (Coralis and Hammond, 1992, pp.683-90)

Evidence also suggests that, even if euthanasia were legalised, it would make little difference to the attitudes of health-care professionals. For example, whilst 77% of medical personnel viewed passive euthanasia as being acceptable, only 6% viewed active euthanasia as ever being acceptable. (Coralis and Hammond, 1992, pp.683-90)

Many individuals also state that they feel differently towards medical personnel who admit that they are prepared to carry out active euthanasia, than towards those who are prepared to carry out the more passive forms of euthanasia. For example, Sugarman (1986, p.60-76) found that, in situations of active euthanasia, physicians were perceived more negatively and held to be more responsible. They were also more likely to be perceived as acting outside the standards of the medical

profession. He also found that physicians who engaged in an act of euthanasia were more negatively evaluated than those who attempted, but failed, to save a life.

The difference between passive and active euthanasia can be seen in the fact that "passive" euthanasia, by for example stopping a ventilator, is defined as an "omission". (ie; a failure to take action to prolong a life) In contrast, "active" euthanasia, by for example administering a lethal injection, is defined as a "commission". (ie taking a positive action to terminate a life). As mentioned previously, at this point in time, the Northern Territory of Australia is the only place in the world where the practice of active euthanasia is not considered to be a criminal offence. Although, in the USA, there are already moves being made towards the legalisation of euthanasia, they are being strongly opposed by the American Medical Association, its members being some of the most articulate academic opposers.

In this country, the House of Lords has recently ruled out any possible legalisation of euthanasia, and doctors have also ruled that active euthanasia should have no place in medical practice. They argue that, instead of "mercy killing", mercy should be shown by the effective control of pain and suffering,

For example, Illman (1993, p.21) suggests that, in 99 cases out of every 100, effective pain control could be achieved by pain control specialists. This is supported by research carried out by Baile et al, (1993, pp. 2786-91) who found evidence to suggest that pain and suffering are major contributory factors in those who express a wish to end their lives prematurely.

In Britain and the USA, taking active measures to end someone's life is a serious crime, punishable by as much as life imprisonment. Yet, in other countries, it is treated as a special crime, with lighter penalties. For example, although euthanasia is still technically illegal in the Netherlands, over the past decade it has become an accepted part of Dutch health policy. Each year, doctors respond to requests for euthanasia from some 2700 terminally ill patients. (Nowak, 1992, p.28) However, as long as physicians follow a set of guide-lines on euthanasia, issued (in 1987) by the Royal Dutch Medical Association, they will not be prosecuted.

The views of medical ethicists on active euthanasia remain divided. Some agree that it allows a patient to maintain rights of contol over what happens to her/his own body. Others are afraid that it could have dire social consequences, particularly if, as

Nowak (1992, p.28) suggests, at least one third of the 5000 or so Dutch patients who receive a lethal injection each year, do not give their unequivocal consent. There are further potential dangers if, as Vincent suggests, there is a hidden agenda in this euthanasia debate. He argues that euthanasia "places us at the vanguard of a demographic catastrophe" because people are living longer. By the year 2025, it is expected that the number of elderly people in this country will have risen by 19%. (1994, Comment - 19/11)

These are the serious issues that must be addressed before it is possible to suggest whether euthanasia can, or more importantly should, ever become a realistic option in the clinical nursing setting. As Meucci (1988, p.17) suggests, in order to understand the growing popularity of the idea of "mercy" killing within public debate, an examination must be made of the psychological and sociocultural dimensions of this expanding social trend. Full consideration must also be given its historical antecedents. Only then is it possible to look objectively at the implications of euthanasia on what might well eventually emerge as a new social policy. Therefore, it is necessary to begin an examination of the issues surrounding the euthanasia debate with an examination of some historical perspectives on euthanasia.

CHAPTER 3

HISTORICAL PERSPECTIVES

When making an evaluation of the problems and possibilities of active euthanasia in the clinical nursing setting it is necessary to begin with an examination of the subject from an historical perspective. However, it is acknowledged that, in the space available, it is impossible to do full justice to the complete history of thought on euthanasia. The historical perspective is particularly important for this particular study because both the supporters of active euthanasia, and those who are against it, cite in their arguments evidence concerning attitudes that have been taken in past generations. These include the predecessors of the various theologians, philosophers, lawyers and the health-care professionals who are at the very centre of the modern debate on euthanasia. (Eg; Downing, 1972, pp.173-92: Trowell, 1973, pp.1-22: Campbell and Collinson, 1988, pp.124-128)

Before beginning this examination it is necessary to make an accurate definition of what active euthanasia is <u>not</u>. Firstly, it is not "assisted" suicide because, in the case of

suicide, an individual takes her/his own life by her/his own action. In the case of an act termed "assisted suicide", there is a clear distinction because that life cannot be ended without the involvement of another individual.

Secondly, it is not the withdrawal or withholding of ineffective treatment, in a situation where an individual is near to death. In this case, the use of such treatment would actually be deemed inappropriate as it would only serve to prolong the process of dying. ie; the very opposite of euthanasia. Nor is it the administration of the kind of strong opiod drugs intended to relieve an individual's pain but resulting in her/his death. This situation is not euthanasia because, not only is the intention different but, it complies with the law of "double effect". In this case, the positive effect of pain relief outweighs the negative effect of a possible early death. (Wilkinson, 1988, pp.304-305)

Of the writers who engage in the debate surrounding the possibility of active euthanasia from an historical perspective, some argue that there is no open condemnation, in ancient writings, to the taking of life in this manner, suggesting that the non-judgemental attitudes expressed in these very early books

can be seen as reflecting the actual attitudes towards both active euthanasia and suicide taken in ancient Israel, as long ago as 1100 - 600 BC. (Trowell, 1973, p.2)

For example, one of the earliest recorded requests for euthanasia, made by an individual who is facing certain death, comes from the Old Testament. King Saul, the first king of Israel, mortally wounded in battle, asked his armour-bearer to "dispatch him", lest he should be captured by the Philistines. (1 Kings: 31)

In the Graeco-Roman world, the Stoics saw human beings as being rooted in the "natural" world, and thus, the individual's duty was to follow nature; each individual was free to take her/his departure from life whenever s/he tired of it. This high degree of personal choice is reflected in the way in which Seneca (AD.65) is quoted as saying:-

> I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys my faculties one by one, if it leaves me not life but breath, I will depart from the putrid or the tottering edifice. If I know that I must suffer without hope of relief I will depart not through fear of the pain but because it prevents all for which I would live.
> (cited in Rachels, (1986) p.9)

However, in examining this evidence, it is important to note that it is difficult to trace the history of the concept and practice of euthanasia in the terms in which it is accepted in the present-day for two valid reasons. Firstly, because it was not distinguishable from suicide until the modern period; and secondly, because the meaning given to the word "euthanasia" in ancient times was very different to that which is now generally accepted. For, example, in classical Greek the word euthanasia was actually used to describe deaths that were particularly easy, happy or heroic, and therefore, was used very rarely, suggesting that it was not practiced as the "mercy killing" that it is generally accepted as today.

Similarly, within the English language, through the centuries, the actual meaning of the word "euthanasia" has changed from a word used to originally to "describe" a pleasant, or happy, death, to the "means" by which a gentle/easy death might be effected, and finally, to the "actions" by which such a death might be accomplished. Therefore, in different civilisations, the word "euthanasia" has moved on from its original meaning of a pleasant/happy death, to be associated with killing, or murder; an act that is regarded as both illegal and unethical. (Wilkinson, 1988, p.30)

Those who would support active euthanasia cite evidence to suggest that not every cultural tradition is as antithetical to the idea of euthanasia as our own Western tradition. In fact, Khuse and Singer would even go as far as to argue that Western tradition is deviant in respect of euthanasia. (1985, pp.107-108) Certainly it can be shown that, throughout history, there have been some tribes and communities, (Eg; the Bushmen of the Kalahari, in Botswana, and the Eskimo people) where something similar to euthanasia has been carried out when individuals faced physical illness which rendered them no longer able to "pull their weight" in the community, particularly where resources were scarce. However, in such cases, euthanasia was only administered after much help and support has been given by relatives, and if the illness appeared to be incurable. (Konner, 1993, p.145)

Although there are recorded incidents of elderly, or infirm, individuals being dragged unwillingly from their huts to be eaten by wild animals, for the most part, the evidence that is cited shows that euthanasia was an act that appears to have been undertaken with the greatest reluctance. It actually arose out of a spirit of self-sacrifice on the part of the ones on whom it was practiced; the older and infirm members of the community

offering their lives in return for the survival of the next generation (Konner, 1993, p.145)

Looking at the history of Christianity, from where it is generally acknowledged that many of the modern objections to euthanasia have arisen, there are also contradictions to be found. For example, whilst there is some evidence to show that the early Christians were pacifists, and therefore, opposed to all forms of killing, it has also been shown that early Graeco-Roman converts held very relaxed views towards both suicide and euthanasia, committing suicide all too easily, often for very morbid reasons. As the number of such deaths increased it became necessary to prevent this morbid sacrifice of life. The modern Christian teachings which condemn both suicide and euthanasia are thought to have been strongly influenced by the reaction of theologians, such as Augustine, to the excesses that occurred during that period. (Trowell, 1973, p.8)

Similarly, in examining the history of the Roman Catholic Church, which is generally acknowledged for its unwavering condemnation of both suicide and euthanasia, it is possible to show evidence that there are, none-the-less, inconsistencies with regard to active euthanasia. (Campbell and Collinson,

1988, p.126) For example, Sir Thomas More, who was prepared to face execution, rather than deny the supremacy of his Pope, wrote in his visionary work Utopia, (1516, p.158) about the possible benefits of active euthanasia in the following passage:-

> Such as be sick of incurable diseases they comfort.... But if the disease be not only incurable, but also full of continual pain and anguish; then the priests and the magistrates exhort the man, seeing he is not able to do any duty of life, and by overliving his life is noisome and irksome to other, and grievous to himself, that he will not be unwilling to die, but rather take a good hope to him, and either despatch himself out of that painful life, as out of prison, or a rack of torment, or else suffer himself willingly to be rid of it by other. And in so doing they tell him that he shall do wisely, seeing by his death he shall lose no commodity, but end his pain. And because in that act he shall follow the counsel of priests, that is to say, of the interpreters of God`s will and pleasure, they show him that he shall do like a godly and virtuous man.
> (More, cited in Campbell and Collinson, 1988, p.126)

More`s acceptance of the fact that there are certain times when the prospect of an early death at the hands of others is preferable to living the kind of life that is left, can actually be seen as reflecting many of the arguments in favour of active euthanasia that have been put forward in the modern debate.

Looking at the historical debate from the point of view of the involvement of health-care professionals, for example, in

early Graeco-Roman times,

> it is difficult to determine the degree of involvement of physicians in assisting suicide, for those sick in mind but not in body, or, in administering the lethal drug in euthanasia for those who had an incurable disease.
>
> (Trowell, 1973, p.6)

There are numerous examples given of individuals requesting active euthanasia, of physicians giving advise concerning the "incurability" of any particular complaint, and even of physicians supplying poison to these individuals. However, there is no record, (nor has any passage been traced) of a physician actually administering a lethal draught to his patient. (Trowell, 1973, p.6)

The starting point for the growth of the modern movement to legalise active euthanasia can be seen as arising out of the humanitarian feeling that began at the end of the eighteenth century. However, in this country, the modern debate is generally regarded as beginning with the first published article advocating (voluntary) active euthanasia. An article written by Lionel. A. Tollemanche, in the Fortnightly Review, entitled "The New Cure for Incurables" was the starting point for an ongoing discussion which, later the same year, was also taken up in the

Spectator. (Tollemanche,1873)

The real beginning of the professional debate began with the Presidential Address of the Society of Medical Officers of Health, in 1931. The presidential address, given by Dr. Killick Millard, proposed that (voluntary) active euthanasia should be legalised for adults (over 21) who were suffering from an incurable, fatal, painful disease, claiming that,

> without such legislation vast numbers of human beings are doomed to end their earthly existence by a lingering, painful and often agonising form of death.
>
> (Millard, 1931, cited in Trowell, 1773, p.14)

This suggestion, not only found favour with many influential public figures but also, surprisingly, with several high-ranking Anglican clergy of the time, such as Dr. William R. Inge, the Dean of St. Paul`s Cathedral. (Wilkinson, 1988, p.307)

When the actual Bill was introduced in the House of Lords, by Lord Ponsonby in 1936, it was defeated at the second reading by 35 votes to 14. It was argued that, not only would it be too difficult to ensure that the necessary stringent safeguards were met, but also because it would place an impossible burden upon the dying. In New York State, USA, a similar Bill, put

forward to the Nebraska Assembly during the same period, met a similar fate. Thus, although attitudes can be seen as changing at this time, even within the Church, the implementation was considered too difficult, and the possible implications too great.

To date, every attempt at legislation in Britain has failed and, even in 1994, (when the most recent attempt was made to legalise euthanasia) it was possible to see that little had actually changed. As in earlier times, it was stated that there were many arguments in favour of this practice. Yet, within the House of Lords, the Church, the health-care professions and the general public there are still, today, concerns about the complexity of the various medical, eithical and legal issues that would be raised by such legislation. (Soloman et al, 1993, p.14)

Much of this concern comes from the fact that, today, the term "active euthanasia" can be used in two different contexts Firstly, there is a clinical context, in which euthanasia is often put forward as a means of either preventing, or relieving, an individual's suffering from some painful incurable disease, or disability. Secondly, there is the social context, in which active euthanasia might be proposed as a way of removing from society individuals from society whose continued life is deemed

undesirable; this was the very reason why euthanasia was practiced by the Nazi Germans during the Second World War. (Trowell, 1973, p.16)

It is within the clinical context, with all the associated medical, ethical and legal problems that this form of ending of human life can give rise to, that euthanasia has more recently become the subject of increasing public concern, and political debate. Yet, many of the fears that are associated with euthanasia are because of the possibility that it might be used for political or social reasons. For example, active euthanasia could be viewed as a solution to the social and economic problems that arise as a result of the presence within the population of a large number of dependent sick, elderly or disabled individuals who place an immense strain on a nation's finite resources. The call the very elderly make on health services is over eight times that of a middle-aged person. In this country alone, according to the study Britain in 2010, carried out by the Social Policies Institute, by the turn of the century, there will be (an estimated) one million people over the age of eighty-five. (Milhill, cited in Field, 1991, p.20)

In making an examination as to whether or not active

euthanasia can ever really be considered a realistic option within the clinical nursing setting, it is necessary to consider euthanasia fully in both contexts. In the former case euthanasia could be viewed as being ethical in that the relief of pain and suffering is one of the aims of good nursing practice, in the latter case the "good of the one who is to die" may not be a primary consideration, and therefore, would not be in keeping with the U.K.C.C. code of professional conduct. (U.K.C.C., 1992) Ethical nursing practice must always be guided by firstly, the principle of non-maleficence, (ie; "above all, do no harm") secondly, the principle of beneficence, (ie; an obligation to help others) and finally, a respect for the autonomy of the individual patient. (Gallagher, 1992, p.54)

Thus, it can be demonstrated that the question as to whether or not a particular action, or omission, can be seen as ethical behaviour can have an important effect upon the present and future role of the health-care professional when caring for those who are at the end of life, and therefore, it is these ethical considerations which must now be carefully examined.

CHAPTER 4

ETHICAL CONSIDERATIONS AT THE CLOSE OF LIFE

For health-care professionals, decisions about the kind of medical treatments that should, or should not, be given at the end of life are more difficult than they have ever been, raise new ethical questions, and increase the need for nurses to become autonomous moral decision-makers. (Rumbold, 1993, p.1) For both the general public and the health professions, the role of "arbiters of life and death" is a burden that can only be successfully borne on a solid foundation of careful ethical thought. In its most basic form, this is concerned with questions such as "what ought we to do?", (ie; the deontological argument) and, "what is the best thing to do?" (ie; the teleological argument) in any given situation. These questions need to be addressed both individually and collectively. (BMA, Working Party on Euthanasia, 1988, p.4)

Whereas the teleological argument, views ethical decisions (and actions) in terms of their consequences, the deontological argument determines what is ethically "good" or "bad" solely

upon whether or not it conforms to out duty, or obligation. Thus, in order to examine fully whether or not active euthanasia can ever be considered a realistic, or desirable, option within clinical nursing practice, it is the application of these ethical principles to health-care at the close of life that must now be considered in some depth. (Rumbold, 1993, p.49)

Nurses working within the clinical setting, particularly those, like myself, who choose to work within the area of care of the elderly, regularly have to accept the fact that death is often the "natural" outcome of their relationship with a patient. In fact, without such acceptance it would be extremely difficult to work within this area at all. However, the practice of health-care is now conducted in a climate where two major influences are in tension. (BMA Working Party on Euthanasia, 1988, p.3)

Firstly, during the three decades that I have practiced as a nurse, medicine has gained dramatic new capabilities to prolong life. For many elderly people this has resulted in a welcome prolongation of "meaningful" life. For others, it has resulted in the prolongation of a life that is of poor quality, raising the question as to whether such an intervention is actually a benefit or a burden, for either the patient or their families.

Secondly, there has been a change in the relationship between nurse and patient, with an increasing importance attached to individual autonomy. The trend is a move away from paternalism, (ie; the professional deciding what is best for the patient) towards the full involvement of the patient in the decision-making process. Through the nursing process, the patient, and her/his family, are not only encouraged to become involved in the identification of needs and the planning of care, but are accorded the right to make ethical decisions on their own behalf. (Rumbold, 1993, p.49) For example, in my own nursing practice, if an elderly patient makes a rational decision to refuse food, that decision must be respected, whereas, in the past, that decision might well have been overridden.

Working with the very elderly it is easy to see that life does actually become a burden for some of the patients in my care, and I would always wish to respect their autonomy. Yet the difficulty arises through the fact that it can actually be very difficult to establish whether some of these patients are rational, and therefore, competent to make a free and fully-informed decision. For example, in certain situations, it can take a considerable amount of time to assess when an individual patient is suffering from dementia, particularly in the very early stages,

when they can actually appear to be very rational. If euthanasia were ever to be legalised, this is where one of the major difficulties would lie.

For many British doctors and nurses there is a crucial distinction between the acceptance of the fact that the time has come to refrain from administering further treatment which will serve only to prolong the process of dying, (ie; a decision to "let nature take its course") and the deliberate administration of a drug for the explicit purpose of terminating a life. This distinction is shown clearly in the following well-known statement made by A.H. Clough:-

> "Thou shalt not kill: but needst not strive
> officiously to keep alive",
> (Clough, 1849, cited in Wilkinson, 1988, p.295)

The intentional killing of a human being is the offence which society condemns most strongly because, at the heart of civilised society is a fundamental belief in the special worth of human life; a value upon which others are based. However, whilst it is a fact that most of us would regard the killing of another human being as being wrong, some would argue that it is acceptable under special circumstances, where it can be seen

as avoiding a greater evil, such as the protracted suffering of another human being. For example, whilst the Royal College of Nursing argues that "each person is unique and of individual value", it also accepts that professionals should respect the varying beliefs of their patients "since care and treatment should be considered in terms of the patients personal values" (Report of the BMA Select Committee on Medical Ethics, 1984, Vol.II, p.71)

The international Council of Nurses views the responsibility of nurses as being fourfold: firstly, to promote health; secondly, to prevent illness; thirdly, to restore health, and finally, to alleviate suffering. Similarly, the Hippocratic Oath requires each doctor to prescribe treatments that,

> shall be for the benefit of the patient, according to my ability and judgement and not for their hurt or any wrong.
>
> (cited in Wilkinson, 1988 , p.112)

Thus, it is the duty placed upon health-care professionals to "do good" and "do no harm" which nurses and doctors are obliged to take into account when carrying out their duties. (Melia, 1989, p.16)

A recent international survey, examining nurses` attitudes

towards active euthanasia (n=319), found that the greater majority of nurses questioned could not justify active euthanasia on ethical grounds. (n=264) Of these nurses, the geater majority believed that, even in a situation where active euthanasia were legal, it would remain unethical for health-care professionals to participate in active euthanasia. (n=232) (Davis et al, 1993, pp.305-309) Of those who claimed that they could ethicly justify active euthanasia, (n=55) the most frequent justification was the "severe suffering of the patient". ie; "the quality of life" principle. (n=45) The second most frequent justification was "adhering to the patient`s wishes". ie; the principle of "autonomy". (n=22)

Whilst health-care professionals can be viewed as having an ethical obligation, whenever possible, both to save and extend the lives of the patients entrusted to their care, they also have a duty to relieve their patients` suffering. There are, however, certain situations where these ethical principles can be seen as coming into conflict because, adhering strictly to the former, may result in a failure to attend to the latter. For example, upholding the "sanctity of life" principle", (ie; <u>all</u> human lives are equally valuable and inviolable, irrespective of their quality or kind) can have the undesired effect of prolonging

an individual's suffering - a situation that would not be in the patient's best interests because s/he could not benefit from the efforts made on her/his behalf.

In fact, Khuse and Singer would go as far as to say that there are certain situations where, not only would a strict adherence to the "sanctity of life" principle be of no benefit to an individual patient but also, it might actually inflict great harm. (1989, p.207) Their paper considers the case of baby Stephanie Christopher, who was born with epidermolysis bullosa, causing widespread and constant blistering of the skin, both externally and internally. In recognising the sanctity of her life as the primary obligation, her doctors and nurses made the decision to carry on with antibiotic therapy (and to use manual stimulation should she stop breathing spontaneously) even though her condition had consistently failed to improve. Considering Stephanie's poor prognosis these actions could be regarded, not only as a failure to act in her best interests but also, because of her protracted suffering, having caused her even greater harm.

In this country, the Appeal Court (1990) ruled that "Baby J" should be allowed to die because he was so

badly brain-damaged that he would probably be permanently blind, deaf, asphasic and paralysed. In the opinion of Lord Donaldson, Master of the Rolls, he would neither be able to comprehand the world around him, nor interact with it. The BMA, in their support of the ruling, suggested that:-

> when we are unable to cure patients there is a balance between what doctors may be able to do in terms of lengthening the person's life, and the inappropriate and intrusive use of medical technology which may cause harm.
>
> (Ellis, 1990, cited in Cox, 1991, p.21)

Despite the commitment that holds the sanctity of all human life, there are few health-care professionals who would argue that all life must be preserved, for as long as possible, regardless of its quality. Had the decision concerning Stephanie been based upon the principle of compassion, rather than the principle of "sanctity of life", the best (or least harmful) alternative might have been for her to die sooner. After all, as Cook argues,

> the compassionate person is looking for alternatives to the present pain and situation, .. [and] .. these can only be pursued if the motives, rights, and consequences are fully weighed.
>
> (Cook, 1983, p.159)

The argument from compassion maintains that euthanasia is

justifiable in such cases of protracted suffering, because that life can no longer be said to hold any value (or potential value) for that particular individual. (Harris, 1985, pp.82-83) Thus, whilst the preservation and prolongation of life can be viewed as fundamental goals of clinical nursing practice, in certain situations they may not always be viewed as the primary goals. For example, what would be the primary goals of nursing practice in the case of an elderly person who is in the process of dying painfully from lung cancer and who goes on to develop a chest infection? Certainly, to preserve or prolong the life of that individual by the aggressive use of antibiotic therapy would be viewed as being "meddlesome". It would also be viewed as inappropriate because, such an action could not be seen as being of any benefit to that patient, nor in the patient's best interests. In fact, the pneumonia that would necessarily develop as a result of that decision would bring a merciful and quick death, rather than the protracted suffering that might be expected if such a death were prevented. This decision would be in keeping with the principle of non-maleficence. (Cassidy, 1993, p.430)

Thus, for the patient who is near death, or for whom death is the only prognosis, the primary goal may, in fact, be that of

the relief of symptoms, and the preservation of dignity; especially in a situation where such actions are in keeping with the wishes of a "competent" patient. The codes of nursing and medical ethics assume that the "person-to-person" relationship that exists between the health-care professional and the patient is one in which the overriding concern is that of the care and benefit of the patient. Thus, the code of ethics is concerned primarily with the "duties" of the professions, rather than with the "rights" of the individual patient. (Wilkinson, 1988, 114)

In Holland, The Dutch Supreme Court, has tried to reconcile the responsibility to respect the wishes of those who want euthanasia with the responsibility for the effective protection of human life. Its new law on the regulation of euthanasia states that any physician who has committed euthanasia can appeal to a defence of "necessity". under article 40 of the Dutch penal code. (Helme, 1991, p.27) This appeal can only be made in cases of an "emergency" situation, in whch there is an objectively established a "conflict of duties". (Jochemsen, 1994, p.214)

Those who support voluntary euthanasia defend each patient`s "right" to individual autonomy, (ie; the freedom for

patients to choose what happens to their own bodies), suggesting that, in the case of a competent patient, those wishes should always be complied with. For example, the members of The Voluntary Euthanasia Society (EXIT) strongly believe that autonomous adults should be free to exercise the same control over their dying as they do over their living. Its members have constantly lobbied for voluntary active euthanasia to become:-

> the lawful right of the individual, in carefully defined circumstances and with the utmost safeguards if, and only if, that is his expressed wish.
>
> (EXIT, 1980, p.3)

suggesting that the failure to accept "mercy killing" as having a special status within the law of this country is interfering with individual liberty. (ie; it is paternalistic)

In fact, as the previous evidence indicates, the very premise upon which the Dutch Parliament accepted its cabinet`s proposal for the legal regulation of euthanasia was that the law would, while effectively protecting the lives of patients, respect the autonomy of those patients who wanted it. The results of the subsequent investigation into the practice of life-terminating actions in health-care, undertaken by Van der Maas et al, (1991)

would appear to uphold this delicate balance between the "duty of care" and "individual autonomy". Although there were 9,000 requests for euthanasia, (ie; termination of life at the request of the patient) only 2,300 of those requests were actually granted. ie; less than 30% of those who want active euthanasia actually achieve it. (1991, p.670)

These statistics can be viewed as showing that patients lives are not merely being terminated "on demand". However, they can also suggest that the decision whether or not to perform active euthanasia, is not based solely upon the wishes of the patient. Rather, what is happening is the termination of the life of a patient "in a certain condition", at his request. ie; the decision is based upon the "paternalistic" authority of the medical profession, rather than individual patient "autonomy". (Jochemsen, 1994, pp.212-213) Thus, in Holland, such decisions are actually being made under the same "paternalistic authority" that those who would support the legalisation of active euthanasia oppose so strongly.

There are other situations in this society where a weak form of paternalism, which overrides the expression of individual automony, is generally accepted. ie; where it can be seen as

being in the interest of safeguarding the lives of citizens. For example, there are legal restrictions placed upon individual autonomy with regard to the use of controlled drugs. Thus, whilst, in theory, it is possible to suggest that each competent adult individual should be able to make such a decision for themselves, there are, in effect, limits and boundaries placed upon the extent to which an individual can exercise her/his autonomy, because the desires of one individual may sometimes overlap with the safety of others.

It is the generally accepted responsibility of the health professional to respect, whereever possible, the wishes of the patient in all areas of health care. However, serious legal implications can arise in situations where a health professional takes what s/he believes to be an ethical decision to make an active intervention to end a patient`s protracted suffering. The result of such a decision can be clearly seen in the case of Dr. Nigel Cox, referred to earlier. His conviction for attempted murder arose out of his compliance with the wishes of his elderly and arthritic patient, Lillian Boyes. For her, life had become intolerable because the level of the constant pain she suffered due to rhumatoid arthritis, septicaemia, internal bleeding and gangenous body sores life. (Taylor, 1995, p.27)

The administration of a lethal dose of potassium chloride prompted great controversy, with arguments falling clearly into two distinct categories. Firstly, there was the argument that he should not have been prosecuted at all, since he had acted out of compassion, in his patient's best interests, and in accordance with the expressed wishes of both his patient and her family. Secondly, there was the argument that he had breached the ethical code of his own profession. He had also broken the law of this country, and therefore, he should have been dealt with more severely by both the General Medical Council and the courts. It was argued that instead of attempting to end the life of his patient, he should have looked more closely at ways of dealing more effectively with her level of pain, and so improve the quality of the life that remained to her.

In fact, one of the strongest arguments against active euthanasia is that there has never been a greater ability on the part of health professionals to relieve the pain suffered by their patients. With <u>good</u> palliative care and the <u>right</u> level of emotional support, Sheila Cassidy argues, few people genuinely desire an early death. This is an argument which my own long experience with the elderly, and the terminally ill, would tend to bear out. Although she accepts that the pro-euthanasia lobby are

correct in saying that it is not always possible to eradicate all pain, it can virtually always be reduced to a manageable level, allowing a level of quality to be returned to the life that remains. (Cassidy, 1993, p.430) In allowing patients, "not only to die peacefully, but also to live until they die", through good palliative care, the necessity for the introduction of active euthanasia as the only ethical response to patients' suffering is effectively removed. (Saunders, (1986) cited in Martin, 1995, p.29) While palliative measures may not wholly eliminate requests for euthanasia, if well-practiced, they might reduce the anxiety that often precedes such requests.

Although the principle of patient autonomy can be seen as having brought a vital dimension to the ethics of health care, to rely solely upon such "rights-based" arguments when making any ethical decisions that might serve the best interests of an individual patient at the end of life, can lead to the kind of conflicts that have already arisen in the case of Dr. Cox. As the evidence from Holland already indicates, such arguments cannot encompass the whole gamut of ethical decisions that might need to be made in clinical practice, it is often necessary to use some other basis for decision-making. Whereas the ethical responsibilities that are outlined in the professional code of

ethics can be seen as arising from the cultural and religious beliefs of a particular society, what can sometimes be seen as being ethical within clinical practice is not necessarily legal within that society. The legal responsibility that health professionals must adhere to comes from the rules and regulations that a particular society chooses to enact and enforce. (Grant, 1993, p.31)

For the health professional, serious difficulties can arise out of situations where ethical considerations clash with legal considerations, as in the case of Dr. Cox. Such cases highlight the fact that, for euthanasia to become an acceptable part of clinical nursing practice, it is necessary to examine the importance of legislation for the role of the health-care professions with regard to active euthanasia. It is also necessary to examine the possible effects that any future legislation might have upon ethical decision-making in health-care.

CHAPTER 5

SHOULD EUTHANASIA BE LEGALISED?

The changing patterns of both health and illness, together with an increase in technological solutions, means that nurses are forced to address ever-changing dilemmas. In the "real world" of clinical nursing practice, decisions will increasingly have to be made which move beyond the area of what is considered to be a matter of professional judgement to the more "public" area of the law. (Cox, 1991, p.19) A firm line can be drawn between an active decision not to continue with futile treatment, and thus, "allow nature to take its course", and any positive action undertaken with the express intent of ending a life. While the former (unless the omission has resulted from negligence) can be seen as being both ethical and legal, the legality of the latter is dependent upon the country in which the action takes place.

Although euthanasia can be seen ethically as the same act wherever it is practiced, with the same end result, in legal terms, it is classed as a different act in different countries. For example, whilst, as mentioned earlier, in the Northern Territory of Australia voluntary active euthanasia has recently been

legalised, (Cole-Adams, 1995, p37) in the USA it is classed as assisted suicide, and, despite the fact that it is practised openly in the Netherlands, it is also illegal there. As already explained, the reason why there are few prosecutions is due to a working arrangement whereby, if it is practiced within certain guide-lines, no legal action will be taken against those who perform it. (Vardy, 1992, p.11)

At the present time, active euthanasia is strictly against the laws of this country, and any individual found to be assisting in the death of another person will face a charge of murder. Under common law, even if autonomously requested, active euthanasia is seen as an act of pre-meditated homicide. It is no more acceptable in law if it is carried out by a health-professional than if it is carried out by a member of the general public; a stance that is strongly supported by the British Medical Association. (BMA,1988, p.67)

A large percentage of the general public, in this country, is now in favour of the legislation of voluntary active euthanasia. National opinion polls in support of euthanasia (provided that the person who wants to die has signed a request for help in doing so) show that support is growing. (Ellis, 1992, p.34-35) For

example, a survey carried out in 1965 found that 50% of people asked supported euthanasia. Yet by 1993 the figure was 79%. A recent telephone poll on Granada TV's magazine programme, This Morning, found that, of 19,000 people polled, 88% supported voluntary euthanasia. (2/3/95) Similar data has been collected in other countries. For example, a Gallup Poll in Canada showed that, whereas 45% of the population was in favour in 1968, that figure had risen to to 78% in 1990. The figures from polls carried out by Morgan Gallup, in Australia, found that whereas 47% were in favour in 1962, that figure has risen to 73% in 1991. (Helme, 1992, p.717)

While the evidence of these polls suggests an international acceptance of voluntary euthanasia by the general public, this data has to be treated with caution by the health professions and those who hold the power to legalise euthanasia. For example, people very rarely take the time and trouble to respond to such polls unless they hold a strong opinion on the subject. Therefore, the data may represent a biased sample. Furthermore, as many of these opinions are gathered by the use of questionnaires, they may be neither valid nor reliable. The possible implications of such legislation means that, in general, nurses remain unsure in their response. However, they can no

longer ignore the strength of the growing call for legislation. (Darbyshire, 1987, p.27-28)

The key question in the debate on active euthanasia is the question as to whether (or not) it should be legal, for professionals practicing within health-care, to "kill" an individual in situations where it might be justified as the ethical thing to do. ie; those individuals whose "quality of life" is such that it is of no value to that person, and if that person, whilst of sound mind, requests it. Therefore, it is a legal consideration within the debate surrounding active euthanasia that must be examined in some detail.

In relation to the ethical dilemmas already considered in the debate surrounding active euthanasia, the relative importance of the law can be seen as being of limited value because it is a poor nurse who would only consider good nursing practice to be that which does not fall foul of the law. (Fletcher et al, 1995, p.6) Nevertheless, active euthanasia is against the law of this country, and any health-care professional who takes active measures to end the life of a patient, even at her/his explicit request, leaves themselves open to legal charges.

In the case of Dr.Cox, above, the evidence has shown that he did not withdraw or withhold inappropriate medical treatment, nor did he give strong opiate drugs to relieve his patient`s pain which then caused her death. His active intervention did not merely shorten the process of dying, but actually changed the cause of death, and it was this change in the cause of death that led to the charge of attempted murder. (Helme, 1991, p.26) However, although Dr. Cox was found guilty of attempted murder within the law of this country, he was not subsequently removed from the General Medical Council`s register. (Garret, 1994, p.493) This was because, both ethically and legally, there is a clear distinction between an act of euthanasia and that of murder ie. one of motive and intent.

In order to be able to differentiate between an act of euthanasia and one of straight-forward murder, it is necessary to show that the killing be done "for the sake of the one who is to die", thus laying stress upon the motives of the individual who actually carries out the killing. This clearly distinguishes those cases which are more or less uncontroversially murders, from those about which (though clearly killings) there is some doubt. (Foot, 1978, p.34) There can be little doubt that the motives behind the actions taken by Dr. Cox were those arising out of

compassion for his patient, as he clearly had nothing personal to gain by her death. In Uruguay, judges are authorised to forego punishment of a person such as Dr. Cox

> .....whose previous life has been honourable, where he has committed a homicide motivated by compassion induced by repeated requests by the victim.
> (Bassett, 1993, p.688)

While the law in relation to euthanasia in the Netherlands still holds active euthanasia to be, in principle, illegal, it also finds it morally acceptable in cases where a competent patient requests a doctor to end her/his life. The legal basis of this apparant paradox is the "force majeure" wherein the doctor must act. ie; the obligation towards the patient placed upon the health professional, and, the obligation to the law of the land placed upon all citizens. (Van der Wal and Dillman, 1994, p.1347) In Holland, the criteria upon which a physician is exempt from being subject to criminal proceedings places an emphasis upon the conscious, persistent and freely-made decision of the patient. Thus, the importance of the self-determination and voluntariness of the patient to make such a request is stressed. (Dickenson and Johnson, 1993, p.147)

Yet, the study carried out by Van der Maas et al, for the

Remmelink Committee showed that, in almost 1,000 of the 2,300 cases of recorded active euthanasia, doctors either prescribed or administered a lethal drug with the sole purpose of ending a patients life "without a specific request by the patient". (ie; in 0.8% of all Dutch deaths) This decision was found to be most likely to be made in hospital (n=710) and less likely in general practice (n=270) or in a nursing home. (n=50) In some 59% of these 1,000 cases, although there had been no specific request recorded as being made by the patient, doctors claimed that they had gained prior information to suggest that their actions were in accordance with the patient's wishes. In a further 2% of cases the actual reason for euthanasia was recorded as being unclear. (Van der Wal and Dillman, 1994, p.1346)

This leaves almost 400 patients (ie; 39%) in which the motive for euthanasia was clearly not that of a respect for the wishes of the individual patient. However, these statistics only examine the reported cases. More worryingly, in relation to any future legislation regarding active euthanasia, is the data which suggests that 65-75% of physicians admitted to having acted unlawfully by certifying deaths that resulted from euthanasia as being of "natural causes" to avoid further investigation. Thus:-

the data published by the Remmelink Committee and

> by others indicate that the majority of cases in which doctors intentionally shorten patients` lives, either by act or omission remain unnotified, unchecked and invisible to justice.
> (Jochemsen, 1994, p.214)

There are two key factors that indicate the way in which the law can be seen as being crucial to nursing practice, with regard to euthanasia. The first is the way in which the law can be seen as representing society`s judgement on ethical standards within nursing practice. The second is the fact that the law can be seen as enforcing sanctions against those whose behaviour is unethical. This it does in two ways. Firstly, by imposing certain obligations upon those working in nursing practice, and the patients they care for, through the Code of Professional Conduct. (UKCC, 1992) Secondly, by its ability to initiate criminal proceedings against any nurse whose actions (or omissions) are deemed to be outside of the law. Although the nurses governing body, the UKCC, has the power to remove an individual nurse from practice, the court has the power to imprison those whose behaviour has been subsequently judged to be illegal. (Fletcher et al, 1995, p.6)

For example, in the case of Sister Rosin Hart, her necessary adherence to the UKCC Code of Professional

Conduct, required her to report the actions of her collegue Dr. Nigel Cox, in regard to the circumstances surrounding the death of Lillian Boyes. In recording the fact that he had administered an injection of 10.mmol potassium chloride in the patient's casenotes, Dr. Cox had implicated the remainder of the health-care team. Under law, had Rosin Hart failed to report the actions of Dr. Cox she, and her nursing colleagues, could later have been deemed to be an accessory to his actions. (Snell, 1992, p.19)

Current nursing practice has advanced well-beyond the traditional boundaries that were laid down in the past. In current nursing practice, the role of the nurse is no longer that of a "handmaid" to the doctor. However, the extension in the role of the nurse which leads to a greater responsibility for decision-making in regard to patient care, also leads to an increased level of accountability, with the possibility that the consequences for any decision that the individual nurse might make may ultimately lead to a court of law. (Fletcher et al, 1995, p.2) For example, Sheldon (1993, p.14) cites the case where, in 1987, four Amsterdam nurses were found guilty of killing a young coma patient with an insulin injection. Not only did they all lose the right to practice, but three of them were actually

imprisoned. Although the sentences were comparatively short, the case had a huge impact upon the whole of the Dutch nursing profession, forcing nursing organisations to face up to the legal issues surrounding euthanasia.

Within clinical nursing practice, the generally accepted aim in caring for a patient is "to improve (or maintain) the patient`s quality of life". Therefore, any decision regarding active euthanasia must, by necessity, imply that the life of an individual patient is judged as being devoid of quality. However, we cannot really ever know what is another`s quality of life. Thus, it has to be accepted that any attempt that is made to assess the quality of life experienced by another human being must be a subjective judgement. For example, the elderly patient who is suffering from senile dementia has a quality of life which, to the nurse, may appear to be very poor and which, judging from their previous state, may be greatly diminished, yet, because they are unable to communicate, the nurse cannot really know what it feels like to be that particular patient. Therefore, in legal terms, it would be very difficult to establish those patients for whom a request for euthanasia was deemed to be a valid request.

Patient autonomy, and the recognition of a patient`s right

to informed consent are crucial to ethical clinical practice, and lie at the very heart of the relationship between doctor, nurse and patient. This shared decision-making, not only safeguards patients' rights to be respected as persons, but also, to have their personal goals and values given due weight. When entered into in good faith by all sides, and if properly understood, informed consent has several important functions. In allowing patients to say no, not only does it enable patients to retain their human dignity, it also protects them from any unnecessary or unwanted treatment.

However, whilst it is accepted that any decision a patient might make to withdraw consent must be respected by health professionals, autonomy must work in two ways. Thus, patients must not have the right to demand a treatment that those who care for them cannot, in conscience, provide. To legalise voluntary euthanasia would then require a doctor, as part of their practice, to take active intervention to end their patients' lives, (BMA, 1988, p.67) and thus, might also require nurses to collaborate in their deaths.

There could possibly be some way in which those nurses who, like myself - because of their religious beliefs -

prefer not to become involved in the active termination of life at any stage. This is already the case for those nurses who do not wish to be involved in abortion. However, the practical application of such a clause in the situation of euthanasia would be more difficult. With abortion, this practice is usually restricted to the area of gynaecology and those who object do not necessarily have to be employed here. Yet the practice of active euthanasia would potentially take place in all clinical areas and, therefore, it would be more difficult for primary nurses to avoid confronting these situations personally.

Furthermore, if euthanasia were ever to become part of the duty of care, patients feelings of trust and confidence could be replaced by those of mistrust and suspicion, and the fear brought about by such legislation might even result in the very opposite of the happy and dignified death that those who support euthanasia are fighting for.

In Holland, the word "request" has consistently been put forward as the key word which separates euthanasia from other forms of killing and which allows its practice to be undertaken without legal redress. Yet the evidence, to date, already suggests that doctors are moving beyond this criteria to a

situation where the practice of terminating the lives of individual patients is actually continuing in a way which is not adequately controlled by the legal system (Sheldon, 1993, p.15)

Miller and Bor (1989) suggest that, in this situation, these fears can be removed by the use of advanced directives (ie; living wills) which, they argue, can be seen as "foci to tackle future uncertainties, and allow the contemplation of strategies and positive coping mechanisms to increase well-being".Such advanced directives, therefore, should help prevent "crisis formation", (ie; a situation where patients panic because of the loss of control they feel over their condition and treatment) because they would make any interventions, to some extent, pre-planned by the very individuals for whom they are designed. (Millar and Bor, 1989 - cited in Watt, 1995, p.1157)

Therefore, it is now necessary to move on to make an examination of the issue as to whether (or not) the formulation of an advanced directive can actually remove some of these fears, and thus, to some extent the barriers that prevent the legalisation of active euthanasia.

CHAPTER 6

CAN "ADVANCED DIRECTIVES" RESOLVE THE LEGAL DIFFICULTIES SURROUNDING THE EUTHANASIA DEBATE?

In Chapter three it was shown that, from the patient`s viewpoint, active euthanasia can sometimes appear to be ethically justified. However, for the health-professional in daily practice, the respect for patients` autonomy can be seen as competing with the obligation to relieve suffering. The discussion of the legal debate went on to reveal that, even in Holland where it is possible to practice euthanasia openly, (providing certain criteria are met) 65-75% of doctors were recording acts of euthanasia as "death by natural causes".

This evidence suggests that they did not want their actions to be subject to legal redress; evidence that is particularly worrying when it was shown that, in almost 400 of the reported cases of active euthanasia, there had been no specific request made by the patient. There is also some doubt about patient

requests in another 600 cases. The difficulties that this issue raises, with regard to the possible legalisation of active euthanasia, could possibly be addressed and diminished through the use of a living will, ie; securing patients` wishes before they actually become incompetent. (Van der Wal and Dillman, 1994, pp.1348-49) Therefore, it is now necessary to consider whether, or not the use of advanced directives (upheld in law) can remove some of the legal difficulties surrounding the euthanasia debate.

In March 1995, the Law Commission recommended that legislation be introduced that would make advanced directives enforceable in law. At present, there is no law in this country that enforces the advanced directive as a means of directing clinical medical and nursing practice. However, in the USA, Australia, Canada and Holland, such laws have already been introduced. These laws govern both the use of advanced directives, and health-care proxies, as a means of ensuring that the autonomy of an individual patient is respected at a time when s/he is not able to speak for her/himself.

The idea of an "advance information directive" (ie; living will) was first put forward by, Louis Ketner, over twenty-five years ago in an article published in The Indiana Law Review

entitled "Due Process of Euthanasia: The Living Will, a Proposal." (Dickenson and Johnson, 1993 p.142) However, the support for living wills has only begun to emerge as individuals have realised the extent to which their lives can now be maintained in situations which they may, themselves, find unacceptable. The legal justification for the acceptance of the advance directive is based upon the premise that when an individual is "in extremis" (ie. incapable of either giving or withdrawing consent to life-saving treatment) the law always assumes that consent would have been given.

Thus, at first sight, there appear to be several valid reasons for advocating the use of these "living wills". Firstly, there is the argument that patients benefit through an increase in the level of autonomy they are able to experience during a period when self-control over normal daily activities is usually lost. By using an advanced directive the authority for decision-making is transferred back to where it truly belongs; (ie; with the patient) a movement welcomed by medical and nursing professional bodies, such as the BMA and RCN (Watt, 1995, p.1157) Secondly, the use of advanced directives should actually serve to remove any potential dispute between the families (or partners) of the patient and the health professionals

who are administering the care because many of the actual decisions will have already been made by the patient in question.

The recent publicity about living wills has brought an increased awareness amongst the health professions as to the growing number of individuals who are actually completing them. Yet, while active euthanasia remains illegal in this country the advanced directive can only inform care by giving instructions regarding consent to treatment. Therefore, at the present time, they cannot be used in order to request, or require health-professionals to take active measures to shorten the life of an individual patient. However, were they to become a legally-binding document, there appears to be both a considerable confusion and a growing anxiety as to the actions that might be required of the health professional who would be expected to implement them,

Living wills can be seen as having two major defects. Firstly, they often fail in their attempts to ensure that the patient avoids unwanted medical treatment. Take, for example, the case of an American woman with terminal metastatic pancreatic cancer. (cited by Iserson, 1991, pp.19-24 and Gillon, 1991, pp.3-7) This patient had been discharged home to die with the

mutual agreement of all the parties concerned. When she subsequently suffered a respiratory arrest, her husband panicked and called for an ambulance. The full-blown resuscitation attempt, made by the paramedics, was resisted by her family. Yet, she was not allowed to die until she reached the accident and emergency department, where her identity and condition were confirmed.

Although all the parties involved had reached the conclusion that further treatment would serve her no benefit, (ie; they had, in effect, created a "living will") the ambulance staff were morally obliged by their professional code of ethics to maintain this patient`s life. In such a situation, even if the living will was a legal document, would the paramedics take time from an emergency situation to check its authenticity and, in so doing, risk a possible charge of negligence?

The second problem with living wills is that they are difficult to interpret in clinical practice because the information given in the document itself is often unclear and ambiguous. This makes it very difficult to determine whether the patient is actually in the condition that was imagined when the request was made. Take, for example the case of Miss G. (as reported in

The Daily Express 9/1/1996, p.8) who regained consciousness just 72 hours before her mother and doctors were due to apply to the High Court for permission to remove her feeding tube. Miss G signalled (by pressing a button) that she did not wish to have her life terminated, even though this had been her expressed wish prior to her accident. This case is particularly disturbing in view of the fact that the severity of her injuries had already resulted in a diagnosis of "persistent vegetative state".

Thirdy, there is the serious question of how long a living will could be considered to be a valid document. For example, had there had been such a document in place when my (now ninety-nine year-old) stroke patient was eighteen, could I honestly say that I am confident in my interpretation of what her wishes were of over seventy years ago? Furthermore, how can I be sure that, at the time of writing, she fully understood how she would feel over seventy years later? As individuals age, the life they have left often becomes even more precious. They may also become well-adjusted to a certain level of incapacity. In such a situation, it would be very difficult to be absolutely sure that the level of disability that was deemed to be unacceptable to that person aged eighteen would be similarly unacceptable to the same person now aged ninety-nine,

Lastly, a further difficulty that can be envisaged is in deciding whether (or not) each patient is competent to make a request for active euthanasia, especially as not all patients who may appear to be competent are subsequently found to be so. For example, Schade and Muslin (1989) cite the case of a male patient (aged 50) who was no longer responding to the chemotherapy he was receiving for chronic lymphocytic leukaemia. On discussion with his doctor as to his prognosis, he decided (with the consent of his family) that, should his condition deteriorate further, any possible resuscitation attempt would serve no benefit.

However, when the doctor attempted to discuss the issue with the patient again (on the following day) the patient appeared to have no memory of the previous conversation. (1989, pp.39-44) Therefore, whether, or not the patient was actually competent to make that decision at that time must be in question. Yet, had he signed an advance directive at that time, all those involved would have subsequently testified as to his competence to do so.

He may have been suffering from the physiological effects of a prolonged course of chemotherapy. Alternatively, he may

simply have changed his mind about his decision and may not have wished to discuss it further. In my own nursing experience I have found that patients often make statements requesting death when they are feeling particularly vulnerable (often when they are in extreme pain) and can see no end to their present situation. Yet, as soon as they start to feel more comfortable (either in physical or psychological terms) they hold a different attitude. This personal experience is supported by the experience of those who work in hospice-care, such as Sheila Cassidy (1993, p.431) and Mary Peel. (cited in Taylor, 1995, p.128)

In examining the patient`s "right" to autonomy there is always an underlying pre-supposition that any advance directive that an individual patient might make would arise from a sane and rational decision, that is made "freely". Yet, evidence collected by Addington-Hall suggests that, in fact, a patient may feel under pressure to sign a directive that would request death because they think that they might become a "burden" to their relatives. (1994, p.1157) This attitude can be viewed as a genuine wish on the part of the patient to avoid dependency, or alternatively, as a reflection on the level of psychosocial care that is offered by communities today. Illness and old-age are

often seen as burdensome, and carers are undervalued and offered little in the way of support.

It can be accepted that an advanced directive might enable the health-care team to focus more easily upon the individual values held by patients. Furthermore, within clinical nursing practice, the implementation of a living will might actually help to guide the process of decision-making through its ability to inform and clarify each individual patient`s wishes regarding life-sustaining treatment and resuscitation. However, they are in fact, by their very nature, unable to cover all possible scenarios. (Watt, 1995, p.1159) The long experience that I have gained through my own nursing practice would lead me to question as to whether it is truly possible to ensure that, when the nurse is in a situation where s/he has to interpret the wishes of an individual patient, s/he can interpret those wishes in the way that was intended by the patient when they wrote them.

If legislation is passed, nurses will have to have a very clear understanding of, and very clear information on the implications of advanced directives and living wills on their role in clinical nursing practice. The RCN guidelines are cautious in their advocacy of advance directives as "difinitive documents", as

they offer no substitute for communication and decision-making within the health-care team. Furthermore, they may, in fact, be seen as offering simple solutions to complex ethical and legal problems. (RCN Ethics and Nursing Committee Chairman, Steve Wright, cited in Taylor, 1995, p.27) As nurses will, inevitably, become intimately involved in the application of any decision that a patient might make within an advanced directive, it will be necessary for them to fully understand the information that is being communicated to them from the patient, via the "living will". They will also need to be clear about their own possible ethical and legal obligations as "patient-advocates".

Therefore, there will also be a need for any legislation to define fully the nurse`s role in the guidance of patients who are preparing a living will, and, in the recording of that living will. ie; ensuring that the true wishes of an individual patient are being recorded clearly and specifically. This must be clearly stated by the professional body governing nursing practice. (ie; the UKCC) It must be done <u>before</u> any embarkation along the road towards the legislation of an advanced directive (or living will) that might, at some time in the future, be used as a request for voluntary active euthanasia.

It is always necessary for the nursing profession to develop good practice, and to lay down standards and policies that are sympathetic to the needs of the patient. Yet, at the same time, it has to be accepted that there are serious dangers that must be recognised. One of the most important of these being that the first step towards any legislation that might eventually result in the introduction of active voluntary euthanasia might actually prove to be a step too far. Such action may actually put us on "the slippery slope" towards the situation where doctors and nurses are required in law to become involved in the implementation of euthanasia without the need for the individual`s prior consent. Thus, it is the validity of the slippery slope argument which must now be given a full examination.

CHAPTER 7

HOW SLIPPERY IS THE SLOPE?

> Most societies outlaw euthanasia not because they are convinced that it is wrong in every instance, but because they know there is no other way to keep it under control. It is because the line between euthanasia and failing to care is so fine that society has to draw a gross legal furrow.
>
> (Michael Ignatieff, cited in, Crawford, 1991, p.54)

The fact that, in legal terms, "euthanasia is an act of premeditated homicide" means that some form of special defence mechanism must be put into place if such actions are to be validated and justified, and these suggested consequences are to be avoided. (Helme, 1992, p.717) The examination of the ability of advanced directives to resolve the ethical and legal dilemmas surrounding active euthanasia has clearly shown that, as such a mechanism, the advanced directive raises even further issues. Particular difficulties arise with regard to its validity and interpretation. It is for this reason that professional health-care bodies are showing caution in their advocacy of such documents. (Dickenson and Johnson, 1993, p.144)

The "slippery slope" argument against active voluntary euthanasia suggests that, in introducing such legislation,

a generally accepted moral prohibition against the killing of another human being will be removed. Thus, society will begin to move one step nearer to pushing euthanasia beyond what can be seen as its acceptable limits. Once this moral balance is upset, the final consequences might be catastrophic for society as a whole, because it will then be relatively easy to move from a society where active euthanasia is legal for those who request it, towards a society where euthanasia can legally be administered to those who do not. (Nowak, 1992, p.29) This argument would appear to be supported by the findings of the Remmelink investigation.

It is the proposed difficulty in setting effective and "secure limits" on the practice of active voluntary euthanasia, highlighted by this evidence, that has led the House of Lords Select Committee on Medical Ethics to oppose any legalisation of active euthanasia. (1994, p.49) However, many philosophers do not take this argument seriously, suggesting that, with the issue of consent, there exists a conceptual barrier which prevents society from sliding to such depths. Therefore, in attempting to answer the question "how slippery is the slope?" it is necessary to examine whether (or not) the legalisation of active voluntary euthanasia would actually be a discrete step that need have no

other consequences.

From both a utilitarian point of view (Eg; Singer, 1989) and the point of view put forward by a virtue theorist, (Eg; Foot, 1978) it would appear that in some particular individual cases, the arguments put forward against the introduction of legalised voluntary euthanasia might be seen as violation of autonomy - even as an act of cruelty. However, whilst accepting this to be a fair comment in certain situations, those who actively argue against voluntary euthanasia suggest that, nonetheless, it should be prevented. They do so on the principle that to allow euthanasia in these circumstances would be "the thin end of the wedge". In their view, such legislation could eventually lead to the routine killing of all those with incurable cancer, disabled children, the aged, and the mentally ill. Once started, it would then be impossible to close the "flood gates". (Lamb, 1985, p.2)

The evidence already examined concerning the Remmelink Report has already highlighted the fact that it fails to offer an accurate account of the incidence of active euthanasia in the Netherlands. It has failed to do so in two main areas. Firstly, the actual findings laid out in the report of the Remmelink Committee laid an emphasis on the fact that euthanasia was found to be

practiced about 2,300 times in the year (1.8% of all deaths) This, the Committee argued was a much lower rate than had been previously estimated - those previous estimates ranging from 5,000 to 20,000 cases a year - depending on the source. (Eg. Nowak, 1992, p.28)) Yet, if the data is interpreted under a different category a different way, those previous estimates are actually found to be relatively accurate.

The Remmelink Commission defined an act of euthanasia as being "an intentional life-ending act by someone other than the patient and at his request" (my own emphasis) and it argued that those criteria were found to be met in just 2,300 cases. (Remmelink Commision, cited in Gunning, 1991, p.1010) However, when examined under the category of "medical decisions around the end of life", (MDEL) some 8,650 recorded cases (see underlined data on table 1. below) were found (ie;6.7% of all deaths) where actions were performed by a doctor with the explicit intention of shortening life. (Gunning, 1991, p.1010)

If this number is then added to the number of times that the shortening of an individual's life was at least partly the intention of those concerned, (see data maked * on table 1. below) the final total amounts to some 19,675 deaths.

TABLE 1.

MEDICAL DECISIONS AT THE END OF LIFE

Prescribing, providing or administering drugs with the explicit intention of precipitating end of life. (n=3,700 ie; 2.9% of all deaths)	
euthanasia (on request)	2,300 cases
assisting suicide	400 "
life-ending treatment without explicit request	1,000 "
Pain and symptom suppression. (n=22,500. ie; 17.5% of all deaths.)	
with explicit purpose of:- accelerating end of life.	1,350 cases
partly with the purpose of accelerating end of life.	*6,750 "
at least considering probability that this will accelerate end of life.	14,400 "
Withholding treatment (including tube-feeding) without request. (n=22,500. ie; 17.5% of all deaths)	
with explicit purpose of accelerating end of life.	3,600 cases
partly with explicit purpose of accelerating end of life.	* 4,275 "
at least considering possibility that this will accelerate end of life.	14,625 "

(Source: Gunning, 1991, p.1010)

The paper published by van der Maas et al stressed that it was necessary for those interpreting the data to understand that "no treatment could relieve sufficiently the patient`s suffering". (1991, p.669) However, this statement has not been supported by any other available data. For example, one objective survey of a teaching hospital in Amsterdam found that over 54% of cancer patients were inappropriately treated with regard to pain-control, and as few as 29% received pain-control that could be considered to be at an "optimum" level. The study indicates that many Dutch physicians use a morphine overdose when they wish to shorten a patient`s life, ie; as a means of euthanasia. Therefore, the intentional use of morphine in this way should actually be termed euthanasia. (Zylicz, 1991, p.1150)

Furthermore, whilst active euthanasia might be seen as starting in the hands of a very few cautious and responsible people, should it go on to become a "mass phenomenon" the same standards might not be upheld. (David Callahan, director of the Hastings Centre, cited in Nowak, 1994, p.29) For example, a research of twenty-six individual cases in the Netherlands, carried out by Dr. Carlos Gomez as part of a doctoral thesis, showed that while the majority of cases did

indeed meet the legal criteria for euthanasia, a further four did not. Firstly, there was the case of a doctor who admitted injecting a badly-injured child with a lethal dose of potassium chloride in order to spare the family further suffering. The second and third cases were elderly people where, according to the doctors, their wishes were unclear, but who were unlikely to make a quick recovery. Lastly, and perhaps most worrying from the point of view of the slippery slope argument, is the killing of a two-day old child because it was suffering from Down's syndrome.

The use of "exceptional" cases as an argument for a change in the law, (ie; those that are already to a great extent seen as justifiable in medical, ethical and legal terms) might indeed leave those who would be expected to administer euthanasia working at the very edge of the "slippery slope". There is a parallel to be drawn between the increases seen in the Netherlands as a result of a weakening of the law with regard to euthanasia and the weakening of the abortion law seen in this country since the 1967 Abortion Act. Whether one agrees with it in principle, or not, there were over 190,600 legal terminations of pregnancy carried out in the year 1991, compared with approximately 133,100 in 1971 - a rise of

some 43%. (Great Britain. (Source: Social Trends,1996, 26:62)

In addition, further amendments to the laws governing abortion no longer restrict the termination of pregnancy up to the 24th week of gestation under certain circumstances. (Eg; of severe handicap) Therefore, the evidence shows that the introduction of this law, which was designed not only to tighten control over abortions that were already being carried out illegally, but also to protect from prosecution any doctor who was acting in "good conscience", has resulted in a huge increase in the number of terminations each year; many for social reasons.

The apparently real fears that euthanasia might come to be used for social, rather than compassionate reasons might appear, to some extent, to be justified. Not only because of the worrying evidence, but also, in the light of the type of comments made by politicians, such as the U.S. President Bill Clinton, who see living wills within the context of fiscal policy. In an interview with the U.S. National Broadcasting Corporation, (November, 1994) Mr. Clinton suggested that:-

> there is a lot of extra cost in medical care at the end of life, and getting more Americans to sign a living will is one way to weed some of them out.
>
> (Shapiro and Bowmaster, 1994, p.39)

As the elderly population grows, there will be more elderly people dependent upon fewer younger people. In fact, it has been suggested that, before long, there will be one working generation supporting two generations of retired people. (Help the Aged, cited in George, 1995, p.20) Therefore, if the attitude of society towards that dependence cannot be changed, active euthanasia has the potential to become a eugenic, rather than an ethical, issue. The recent changes in the way that community care is funded mean that, in the future, the cost of caring for the elderly in our society is going to place an increasing strain upon individual resources. Families can no longer rely upon the state to provide the funding for community care. This, in turn might effect the way in which both patients and families view euthanasia. (Addington-Hall, 1994, p.3) Age Concern agrees that these uncertainties about the future of community care have left both the elderly and their carers more fearful about the future than ever.

Those who support active voluntary euthanasia suggest that, in fact, it is the principle of "consent" which provides a "conceptual barrier" between the killing of those who wish to die and the killing of those who do not wish it, and therefore, against the potential abuses outlined in the "slippery slope" argument

against such legislation. The concept of "consent" already governs many decisions about medical treatment, and therefore, can be seen as being at the heart of the relationship between doctor, nurse and patient. However, although it can be accepted as a fundamental principle that an individual has the right to refuse their consent to any particular medical treatment, the principle of "consent" - when used in the argument for the legislation of euthanasia - raises very different issues.

For example, the Dutch newspaper, NRC Handelsblad, is already quoted as reporting that there are now large numbers of elderly people being subjected to euthanasia against their will, and, in order to encourage his more "reluctant" patients to request euthanasia, one Dutch specialist admits,

> the only thing I have to do to get a request for active euthanasia is to shoot them up with a cytostatic agent, ignore their pain and above all, devote little time to them.
>
> (Independent, 12/5/1990)

Thus, it can be seen that it is possible that any procedure introduced for consent might not only prove to be inadequate enough to allow misuse, but also liable to the biases of those who implement it. Although we cannot generalise the behaviour of one particular doctor to the whole medical profession, it does highlight some of the potential difficulties that could arise if

legalised. Even though such unethical actions could be dealt with by the law, it is not difficult to imagine the anxiety and insecurity such a case would induce in some of our patients.

The legal structures to any bill involving voluntary active euthanasia would be very difficult to bring into place because, on the one hand they may be seen as being too rigid, and therefore, too restrictive. Yet, at the same time there must be seen to be some form of tight legal control over any actions undertaken by one person that results in the death of another. (Clark, 1993, p.126) Recent information on developments in the Netherlands has seemingly added weight to the arguments that the acceptance of the principle of voluntary euthanasia for those who can be shown to have consented to it would, in fact, lead society to the very edge of the "slippery slope" to involuntary euthanasia for those who have not. The Dutch experience has highlighted some of the more desirable aspects of euthanasia, such as patient autonomy and compassion. However, it has also highlighted some of the more undesirable effects of accepting a policy of "voluntary" active euthanasia, particularly as the blatant disregard for the regulations laid down is not limited to any single incident.

The more widespread the practice of euthanasia, the more likely it is that abuses will occur. Whilst, it has been shown that, in particular cases, and under certain circumstances, euthanasia can be justified on both medical and ethical grounds, nurses and doctors do not inhabit a world where conceptual boundaries, and clear-cut distinctions, are easily identified. In clinical practice,

> "the truth, is not always to be identified with rational distinctions between concepts, but is found in their necessary interpretation".
>
> (Lamb,1986, p.120)

Whilst it is accepted that terms such as "voluntary" euthanasia, and "incurable" disease, all individually highlight what can be seen as sharp distinctions, within the reality of the euthanasia debate it is extremely difficult to retain the absoluteness of these distinctions.

For example, when following the rules of the road it might not be seen as being a necessity to stop at every red traffic light on a particular journey. In some circumstances, (Eg. an emergency) it might even be justifiable (ethically) to jump a red light. Yet, to actually change the entire traffic laws to allow for a few particular circumstances would be deemed inappropriate as traffic laws could become more difficult to uphold. (Veatch, 1978, p.97, vited in Lamb, 1985, p.120) The same arguments

can be applied to the laws governing active euthanasia. As the House of Lords Select Committee have already pointed out, if the laws governing the taking of human life are re-drafted in order to make allowances for individual situations, (even though they may be ethically justifiable) it would inevitably weaken the prohibition of intentional killing within this society. (1994, p.48) The law already has the power to take mitigating circumstances into account with regard to euthanasia through the kind of penalty it enforces on those who break it.

For the health professional, attention to good practice is of vital importance in maintaining a balance between compassion and clinical expertise. When examining individual patient care, it is usually the nurse who establishes the most intimate relationship with both the individual and the family. It is often the primary nurse who is left to both interpret, and to actually carry out, the treatment agreed upon. Unfortunately, in my own experience, there are sometimes situations where the values and beliefs of the nurse (and, in fact, the patient and relatives) come into direct conflict with those of the doctor who makes the overall decision. This incongruence often results in effecting the quality of care provided.

Whilst it is important, at all times, to respect the individual`s need to be autonomous, to be "in control" of the manner of their dying, the values and beliefs of nurses (and doctors) also have to be considered. Many nurses, either because of their personal value system - for example, their religious beliefs or, their beliefs about their role as preservers of life - cannot come to terms with the idea of active euthanasia, and the possibility that it might be necessary, in the future, to take on the role of "killer" as part of their nursing practice. (Chadwick and Todd, 1992, p.180) As Cannon Roger Royle points out:-

> People should be allowed to die with dignity, but without giving someone else the burdensome task of killing them.
>
> (Cannon Roger Royle, Radio 2, March 1995)

It is now important to move on to examine whether (or not) nurses` attitudes can ever actually be "changed" in such a way as to make active euthanasia an acceptable part of their role as care-giver. Therefore, it is also necessary to establish the extent to which nurse-education plays a role in the development of the beliefs and values held by nurses. In doing so, consideration must be given both to those presently working within clinical practice, and the nurses of the future.

CHAPTER 8

MIGHT NURSES EVER KILL?

New occasions teach new duties:
Time makes ancient good uncouth;
They must upward still, and onward,
Who would keep abreast of truth.

(Lowell, 1844, cited in Curtain and Flaherty, 1982, p.68)

This statement, from The Present Crisis by James Russell Lowell, can be seen as being particularly relevant for nurses working in the clinical setting today. As society is undergoing a rapid evolution, and medical and technical knowledge is increasing, there are ever-increasing responsibilities being placed upon members of the nursing profession.

These new responsibilities, both personal, professional and legal, will necessarily lead nurses to question the application of any proposed practices that relate directly to patient-care. As a result nurses, as members of society, may have to re-think and re-define their personal value systems. They may also, as professionals, have to examine constantly new information that their prior education and experience may not have fully prepared them for. (Curtain and Flaherty, 1982, pp. 70-76) For example, my own role as a practitioner today,

and the level of responsibility that it demands, is greatly extended from the role that I was originally trained to occupy almost thirty years ago. The UKCC requires that those nurses who would wish to maintain their role must constantly update, and extend, both their practical skills and, the theoretical knowledge-base which underpins their practice.

It is now possible to delay the moment of death in almost any life-threatening condition. Therefore, nurses are frequently faced with situations where a patient will not die until a decision has been made to withdraw, or withhold, some form of life-sustaining treatment. Many medical decisions at the end of life are now made in consultation with the primary nurse, (or nursing team) rather than being made solely by the doctor involved; decisions which could have legal repercussions for those involved. Even when decision have been made by doctors without such consultation, nurses still have a professional and legal responsibility towards the patients for whom they are the named nurse. It was this responsibility that required Sister Roisin Hart to report the case of Dr. Nigel Cox.

When it comes to deciding what ,as practitioners, nurses should do when they are faced with a situation where active

euthansia could clearly be an an acceptable option for an individual patient, the nursing profession is no different from the remainder of the general public, in that there is no consensus of opinion. Even if nurses disagree with the concept of active voluntary euthanasia, they need to be able to offer a sound argument as to the reasons why the accepted practice of "allowing" patients to die should be preferable to that which involves the taking of a positive action to help them die.

This is especially important in situations where this is the patient`s express wish, and where any extension to the process of dying is clearly not in that patient`s best interest. There can be few of those nurses who work in the clinical setting who have not experienced a situation where the patient no longer appears to be benefitting from the measures that are being taken on her/his behalf. This is particularly true of those who work regularly with terminal patients, or those, like myself, who work with very elderly, sick people.

With the issue of active voluntary euthanasia, the dilemma arises because, although it is accepted that health professionals have an ethical obligation to maintain and extend human life, they also have an ethical obligation to relieve suffering in their

patients. Nurses have been assisting patients to die for countless years; and, for example, the act of administering the extra dose of morphine which helps terminally ill patients "on their way" has rarely been questioned. Thus, failing to prolong the life of someone who is in the final hours, or days, of life has long been viewed as acceptable practice.

However, whilst many nurses can justify this more "passive" form of euthanasia, recent international research evidence (ie; USA, Canada, Australia, Peoples Republic of China, Finland, Sweden and Israel - (n=319)) suggests that the great majority of nurses cannot ethically justify voluntary active euthanasia. Even if the law were changed to make voluntary active euthanasia legal, the great majority believe it would remain unethical for health professionals, and especially themselves, to participate in such actions. (n=223) (Davis et al, 1993, p.301-309)

Those who did support it, did so firstly, on the grounds of their patient`s suffering (n=45) ie; the "quality of life" principle, and secondly, on the grounds of the patient`s wishes (n=22) ie; the principle of patient autonomy. (Davis et al, 1993, p.309-309) The issue of autonomy was also found to be of importance when

attitudes towards active voluntary euthanasia amongst registered nurses in America were examined. (n=137) (Schuman et al, 1992, pp.1-5.) A survey of Australian nurses (n=943) found that "persistent and unrelievable pain" was ranked as being the most important consideration by 165 of the 502 nurses who had (at least on one occassion) been asked by a patient to hasten her/his death.

Those who would support the introduction of voluntary active voluntary euthanasia suggest that, giving patients the ability to make an informed choice about the timing of death, actually improves the quality of the life that is remaining. Evidence in support of this belief comes from the research undertaken by Owen et al (1994, pp. 1-9) who found that cancer patients who anticipated a future role for the more passive options of wishing death to come early, or ceasing all treatment, were more hopeless (and, therefore, had a reduced quality of life) than those who anticipated the more active options of suicide and/or euthanasia. These patients were less fatalistic. Although the preservation and prolongation of life can be seen as fundamental goals of health-care, they are not the sole ones, and, for example, in the case where a patient is near to death, it can be argued that the relief of symptoms, together with the

preservation of independence and dignity, are perhaps the preferred alternatives.

Yet how, as practitioners, are we to be sure that the individual patient is making such a choice "freely" in a situation where the individual is experiencing severe pain, or suffering from the effects of drug therapy? How can we ensure the individual's continued ability to make conscious, free and rational decisions? Furthermore, (and perhaps, more importantly) how can we be sure that the wishes expressed by the patient have not been influenced by the attitudes of the relatives towards the individual concerned?

Rather than viewing patients' repeated requests for death as a heartfelt desire to end their lives - a wish to remain autonomous in their dying - they could, alternatively, be viewed as a judgement upon the quality of the palliative care that we are offering as practitioners. If all patients could be guaranteed a good level of palliative care, it might, in reducing their fear, make them more autonomous in their living.

This dilemma is further complicated by the fact that, as the end of the 20th century approaches, there are grave

concerns regarding the allocation of health-care resources, and therefore, about balancing the rights of the individual patient with the common good. It is not impossible for those presently working in the clinical setting to envisage a possible situation where, at some point in the future, they may be expected to partake in the limitation of alternative options open to individual patients. This restriction of clinical budgets is, to some extent, already happening. For example, the quality adjusted life years scale (QALY) is already accepted practice in allocating resources, both within and between patients.

It has been suggested that, within clinical practice, voluntary active euthanasia does not actually deserve the vast amount of attention it has been given. There are many other medical decisions which shorten a patients life intentionally that are used more frequently, yet would not meet the criteria for active euthanasia, and therefore, have fewer legal safeguards. (Griffiths, 1994, p.137-58) For example, the report of the Remmelink Committee showed that, in the Netherlands, the alleviation of pain and symptoms, (with such high dosages of opiods that the patient`s life might be shortened) was the most important medical decision concerning the end of life in as many as 17.5%. of all deaths, with non-treatment being the most

important way of shortening life in another 17.5%. In comparison, active euthanasia by administration of lethal drugs at the patients request was only important in 1.8%. (Van der Maas et al, 1991, pp.669-674)

At the present time, as the evidence shows, there are considerable variations to be found amongst nurses as to whether (or not) active euthanasia should ever constitute a part of the nurse`s professional role For example, when the results of the International survey (Davis et al, 1993, pp.301-310) are compared with the survey of Australian nurses, (Khuse and Singer, 1993, pp.311-322) it is found that, whilst the majority of nurses were opposed to active euthanasia in the former, in the latter opinions were much more divided. In the Australian survey, of those nurses (n=218) who stated that they had:-

> been asked by a doctor to engage in an action that would directly and actively end a patient`s life, upon that patient`s request
>
> (Khuse and Singer, 1993, p.316)

85% responded that they had already done so (80% more than once)

However, both these surveys are not without their individual difficulties. For example, in the international survey,

almost half of the respondents were involved in the care of incompetent patients. (n=153) In the Australian survey there were difficulties surrounding the term "taking active steps to hasten death" as the responses given by some of the nurses could not readily be interpreted as pertaining to euthanasia. (McInerney and Seibold, 1995, pp.171-182) For example, one nurse responded to this question by saying that:-

> [patients].....have the right to have as much drugs as necessary to control their pain and ease their death. Usually the doctor does not give direct orders but leaves orders which can facilitate large and often lethal doses being given by the nurses.
>
> (Khuse and Singer, 1993, p.316)

In a survey carried out amongst registered nurses in America, (n=137) acceptance of the idea of active voluntary euthanasia was dependent upon the years of experience within the profession, with more long-experienced nurses being less strong in their acceptace. This evidence suggests that those nurses with a greater experience tend to be more wary of viewing the issue of euthanasia merely in "black and white" terms. (Schuman et al, 1992, pp.1-15) The responses given by the Australian nurses also gives a clear age-related pattern in that the level of compliance with a doctor`s request was found to be 100% in those under thirty, falling to a figure of 60% in those

over sixty.

Furthermore,of those nurses who actually supported the idea of voluntary active euthanasia, opinions were similarly confused because, whilst some would suggest that it is the patient`s wishes that should be paramount, others feel that paramount consideration should be given to situations where the patient can be seen as "suffering". (Eg; through pain that cannot be relieved) (Davis et al, 1993, 301-310)

Therefore, before it is possible for euthanasia to become an option in the clinical setting, there is a need for a much wider debate. Without such debate, the intoduction of legislation permitting euthanasia, rather than solving any part of the present dilemma, would actually lead to the creation of even greater confusion within the nursing profession as a whole. (Blacker, 1992, pp.15-24) The hospice movement has shown that death, for the patient, can be a peaceful process, without the need to resort to active euthanasia. This can be achieved hrough a high level of palliative care, good pain management and a committment on behalf of those in clinical practice to maintaining the individuals quality of life, right up to the very point of death. (Cassidy, 1993, pp.430-31)

Before attempting to legislate for voluntary active euthanasia as an alternative, perhaps more emphasis should be placed upon extending this form of care as a way of giving patients the opportunity to exercise a greater control over the process of dying. It is interesting to note that, in Holland, the board of the Dutch Physician's League stresses the importance of the need for an increase in the type of palliative care offered by the British hospice movement, considering:-

> a request for euthanasia as a request for the right palliative treatment". Specific palliative care is always possible and will sharply reduce the demand for euthanasia.
>
> (Gunning, 1991, p.1010)

When looking at euthanasia, the attitudes and values of those health professionals working within the clinical setting can be very different from those found in their clients. These attitudes, in relation to death and the process of dying, are not only very personal, but often seen as relating to their own reactions to death itself. Thus, in understanding the moral, legal and ethical problems surrounding the euthanasia debate, perhaps, for nurses, the most important factor might be to examine their own feelings and actions surrounding the end of life more closely. Any lack of openness about the question of an

individuals "right to die" can only be seen as increasing the level of stress and isolation felt by health professionals. (Casey, 1994, p.29)

Whether particular nurses like it or not, euthanasia is now "in vogue", and therefore, more and more people will begin to demand the "right" to choose for themselves both when, where, and how, they want to die. (Casey, 1994, pp.25-29) In many areas of nursing practice, (Eg; terminal care and care of the elderly) nurses often enjoy a special closeness to the patient during the period from diagnosis to death. They must now, therefore, re-evaluate their attitudes in order that, in the future, they will be able to make an informed decision about active euthanasia as a possible option within the role they fulfil towards their patients.

It is no longer acceptable for the practice of euthanasia to be disguised as "nursing care only", nor is it acceptable that the law courts uphold such terminology as a way of avoiding the confrontation that arises from the euthanasia debate. Already, in Australia`s Northern territories, one Western, industrialised, Christian country has accepted voluntary active euthanasia as being acceptable within law. It must be assumed, therefore, that

others will follow this lead, including this country. If this should happen, nurses will need to be very clear on the ethical justification for euthanasia, and on their own motives. Meeting the basic health-care needs of patients is just as much a perogative of nurses, as it is of doctors, therefore, the nursing profession must confront the issue of euthanasia now.

The level of indifference presently surrounding the euthanasia debate in this country can be clearly seen by the number of nurses (n=149) who responded to a survey questionnaire by Reg Pyne, (formerly a senior member of the UKCC) that was published in the Nursing Times. (17th May 1995) If nurses continue to show this apathetic response to the issue of euthanasia, should active euthanasia become legal, it would be almost impossible for them to fulfil their important role as patient-advocate. After all, this role is dependent upon the nurse`s ability to both understand and protect the "rights" of the patient, and also to be able to ensure that the patient can exert those "rights" fully. Therefore, it is now necessary to move on and examine the reasons why such apathy exists within the nursing profession.

CHAPTER 9

IS EDUCATION THE ANSWER?

For nurses working within a health-care system that expects them, constantly, to expand their clinical role, and become increasingly accountable for their own professional practice, the ethical and legal dilemmas that are engendered by the changes that have taken place in modern medicine are now going to have to be faced on a regular basis. According to the UKCC`s document Exercising Accountability within nursing,

> each practitioner must determine exactly how this aspect of personal professional accountability is satisfied within her particular sphere of practice.
>
> (UKCC, 1989, p.12)

Throughout the 1980`s, the nursing profession has consistently argued that it is now ready to "embrace the privileges and responsibilities of professional status". Within society, in general, it is already accepted that the professional nurse possesses those characteristics that have prepared them to exercise their proper roles as citizens and as health-care professionals", one of the most important being education. (Curtain and Flaherty, 1982, p.71)

Although a general education equips the nurse to think, reason, and write in an accurate manner, it is the more specific education that they receive that actually equips them with the theoretical basis for professional practice. However, despite the fact that nurse-education is designed to produce nurses who act responsibly in any given life-or-death situation - their actions being determined by what is most (objectively) beneficial for their patient - historically,

> nursing education and nursing service have not agreed on what constitutes the professional nursing role.
>
> (Kelly, 1992, p.121)

To date, there is no major research evidence available as to the potential effects of such dissension on the professional self-concept of those nurses entering the profession. However, it is already acknowledged that the integration of professional role identity and self-concept is dependent upon professional socialisation. (Kelly, 1992, p.121) My own long experience in the clinical setting would suggest that the theoretical ideas of what constitutes the expected role of the nurse, as put forward in the colleges of nursing, does not, (unfortunately, in my own opinion) always equate with the actual experience of the nurse entering clinical practice. For example, studies in professional

socialisation have discovered that students within the nursing profession receive conflicting messages from "the clinical nursing faculty", in general, with student nurses being "groomed for subordination". (Kelly, 1992, p.121) These studies noted incongruities between the classroom emphasis on the individualistic, holistic, caring approach, and the clinical-based experience of task orientation and technical proficiency. (Buckenham and McGrath, 1983; Cohen, 1981; Melia, 1988.) For example, nurse-tutors and mentors are encouraging their students to question practices constantly, and be always sceptical about merely accepting that, just because certain practices have always been carried out in a particular way, that way is necessarily the right way. However, when they reach the wards they are often met with hostility from those nurses of "the old school" who see no reason to question, or change, long-established practices, even where there is evidence to suggest they may be bettered.

When considering the effects of the differing approaches taken by nurses from differing cohorts of nurse-education, with regard to active euthanasia, evidence from the Australian survey, carried out by Khuse and Singer, suggests that "support for a change in the law is stronger amongst younger nurses". Younger nurses, they found, also indicated a

greater willingness to become involved in the actual provision of any legalised active voluntary euthanasia. (1993, p.321)

Therefore, in order to be able to consider fully whether or not active euthanasia can ever be considered a realistic, or desirable, possibility within clinical nursing practice, it is necessary to examine the evidence that is put forward as to the reasons why there should be such a difference in attitudes amongst nurses. It is also necessary to examine whether there will be any difference in these attitudes as a result of the recent changes made to nurse-education, (ie; supernumerary status for students and the introduction of the role of mentor and preceptor) through the introduction of both Project 2000 and PREP.

The discrepancy that can often be seen to exist between theory and practice for today's newly-qualified nurses, (ie; the theory-practice gap - Yassin, 1994, p.183) has arisen primarily because, historically, nurse-education was "dependent upon the prevailing patriarchal world view of power and leadership". (Chally, 1992, p.117) This view of education required the nurse to submit to the power of her/his superiors, and can be linked metaphorically to military training. The well-trained nurse possessed all the important qualities of the highly-trained

soldier, such as obedience to authority. For example, in an early book on nursing ethics Garsche suggested that:-

> (An) exellent help to self-devotion is the love the nurse has for the stern strife of her constant battle with sickness....The stern joy which warriors feel, in foemen worthy of their steel, should inspirit the valiant heart of the brave soldier who bears long night watches, weary marches, dangerous battles, for the love of the conflict and keen hope of victory. The soldier in a just war is upheld by this keen joy of battle. So will the nurse be spurred on to devotion by the love of conflict with disease.
>
> (Garsche, 1929, cited in Chally, 1992, p.117)

In fact, this picture that portrays nurses as trudging up and down the wards, for long hours, whilst obeying the "orders" of the higher ranks, is one that was still in place at both the start of my own nurse-training, and early practice of the mid-1960`s.

It is not only the behaviours of the nurse that can be linked to this military metaphor. The nurse`s uniform of today closely resembles that of the professional soldier in the way that each successive grading requires a change of dress to reflect the changing status of the nurse within the team This analogy is further re-inforced by the idea that, when changes to long-established methods are discussed, (even desirable changes) they are frequently deemed to be "revolutionary".

In the past, nurse-education relied solely upon behavioural objectives that have "attempted to make the essentially creative activity of teaching scientific". (Bevis, cited in Chally, 1992, p.118) This imposed rigidity reduced the education of nurses to a basically technical realm and because of this, educators, in the past, have failed to instill any sense of meaning and vision in their students. A class guided by such a model invariably contained a content that was selected by the teacher/instructor. At the same time, it discouraged any interaction that was seen as being unrelated to the prescribed objectives of the session, leaving the student subject to the power of the teacher/instructor. (Chally, 1992, p.118)

However, for nurse-education to produce those nurses who will be effective within clinical nursing pracitice, it is not enough to "simply fill a student with facts and figures and then expect that individual to make critical decisions about life and death". (Chally, 1992, p.118) Fortunately, further and higher education have, in general, come to appreciate the long-term difficulties engendered by this form of teaching. It could be argued that, today, nurse-education is in the middle of a paradigm shift, with the historical perspectives of the student as being powerless beginning to lose their legitimacy and relevance.

The implementation of Project 2000 has, without doubt, been the largest and, potentially, most positive change that has taken place in nurse-education, because it is aimed at the facilitation of the advancement of nursing as a profession. It has brought with it an end to the older "apprenticeship" style of nurse training that required student nurses to spend a large majority of their training meeting service-needs, rather than evaluating individual patient-care and current practice. Supernumary status, together with the appointment of specific individuals to be mentors and preceptors, is aimed at supporting the theoretical basis of nurse-education by providing each student with an individual teaching and learning method through which s/he can experience day-to-day clinical practice. The relationship between educational and clinical staff is designed to ensure an overall level of competence.

During clinical experience, at the pre-registration stage, and later, in professional practice, nurses may encounter many issues that can be described as controversial, such as those engendered by the euthanasia debate. For example, in attempting to answer the question as to whether (or not) people who have a painful terminal illness should have the right to end their lives, nurses need to learn how to deal effectively with such controversial issues ie; how to discuss opposing viewpoints and

be able to reach some form of agreement with people who might hold a different point of view.

The extent to which student nurses develop the skills they need in order to be able to deal effectively with controversial issues can be dependent upon the particular strategy that educators use when addressing such issues. (Pederson, 1992, p.101) For example, whilst debating has long been a popular strategy to encourage discussion and understanding of controversial within the nursing schools, students are not required to synthesise the strongest points of both positions, and therefore, it does not facilitate an open-minded approach. In contrast, approaches such as the "structured controversy" approach, encourage student nurses to look for the rationale behind the argument, to criticise and paraphrase the ideas of others, and to contribute and integrate information. These students are also more likely to present a rationale for their own arguments, producing higher-quality decisions.

Evidence which supports the need for this form of educational perspective comes from the international survey which found that, prior to the interview, many of the respondents (from each of the seven participating countries) had never given any thoughtful consideration to the ethical issues raised by the

euthanasia debate. (Davis et al, 1993, pp. 301-310) As mentioned in the previous chapter, the survey also revealed a worrying confusion amongst nurses as to the differing criteria by which euthanasia is defined as either active or passive; a finding that was replicated in a comparative study of Chinese and Australian nurses` understanding, and experience, of euthanasia. (Wilkes et al. 1993, pp.95-102)

While the changes that have taken place as a result of the introduction of Project 2000 may have resulted in a narrowing of the theory-pactice gap to some extent, there are already concerns being expressed as to the lack of emphasis being placed upon the importance of ensuring that students have the opportunity to apply learning to practice within a realistic time-scale. Without this, distortions can occur between the theoretical learning and the way it is applied in practice. Similarly, there are concerns as to the actual length of placements within the clinical setting - a concern that is supported by the ENB (1993) - leaving students little time to consolidate their learning and understanding of the experience. (Yassin, 1994, p.184)

Despite the fact that today`s students are being encouraged to think in a more ethical way and critically evaluate

current clinical practises in relation to new concepts there is evidence to suggest that, when qualified, they may still accept current practice without question. (Farley and Hendry, 1992, pp.36-38) Similarly, there is little evidence to support the role of the preceptor as facilitating the successful transition from student, to primary, nurse. A recent study found that the professional socialisation of students was, to some extent, dependent upon the educational level of the individual assigned the role of preceptor. (Ouellet, 1993, pp.16-23)

Whilst it can be argued that such teaching methods are already becoming effective in producing nurses who are able to look theoretically at the issues surrounding euthanasia, such as those of beneficence and non-maleficence, these cannot be a real substitute for the experiences gained in clinical nursing practice. Through a long nursing experience it is possible to gain a different perspective on these controversial issues. For example, the exploratory study of nurses in seven different countries, (n=319) carried out by Davis et al (1993), found that, overall, the great majority of nurses who work with patients who suffer from dementia (n=130) could not ethically justify euthanasia under <u>any</u> circumstances.

Even if the law were changed, only 6% of these (n=25) would change their minds and support active voluntary euthanasia. In contrast, of those nurses who work with cancer patients, almost 20% (n=35) were in favour of active voluntary euthanasia, raising to 30% (n=50) if the law were changed. Therefore, I would suggest that it is the differing clinical experiences of the nurses surveyed that account for the differences found, rather than any specific differences in educational experience. Therefore, not only must careful consideration be given to the way in which the changes now taking place will enhance the role of the nurse as an ethical thinker, but attention must also be given to the practice through which the theoretical knowledge is applied.

It is only when these changes have become the subject of long and ongoing research and evaluation that it will be possible to suggest that nurses are ready to take on the responsibilities that would be associated with voluntary active euthanasia becoming part of their extended role. Many doctors, because of their training and professional socialisation, tend to be able to find it easier to accept a more utilitarian approach to medical decisions. Nurses, however, tend to think in terms of the immediate needs of individual patients. These educational differences must also be addressed before it is possible to

suggest that it would be possible, or desirable, for nurses to partake in active euthanasia. (Dickenson and Johnson, 1993, pp.163)

It will only be when younger nurses gain a wider clinical experience that it will be truly possible to accept the idea of a paradigm shift. Only then, can it be shown that the differences in attitudes found in younger and older nurses are actually a product of the different way in which they were educated, rather than, either the way in which they were professionally socialised, or, a product of their many years of experience gained within the clinical setting.

For example, despite my personal understanding of the theoretical issues surrounding the euthanasia debate, and belief in the importance of patient-autonomy, my own past experience of the ease with which abuses have already taken place in the health - care of very elderly people would lead me to be very cautious of ever accepting the idea of active euthanasia (even on a voluntary basis) within my own particular clinical area. The ethical issues that arise within the clinical nursing setting are often very different, and more complex, than the vignettes and cameos that are offered as examples in academic textbooks. (Eg; Melia, 1988)

Each patient is an individual. Therefore, what might be considered to be acceptable practice (either ethicly or legally) in one particular situation, for one individual patient, would not be the same in a similar situation, with a different patient, nor for the same patient in a different situation. Until the UKCC can produce a set of firm guidelines for making such life-and-death decisions, that can be seen to hold both in ethical and legal terms, the time is not yet right to introduce measures that would make active euthansia either a possible, or desirable part of the professional role of the nurse.

CHAPTER 10

CONCLUSION

Death is an inevitable consequence of life and, as such, it raises a broad range of moral issues. The increasing use of technology, together with the increasingly successful array of treatments now available, mean that it is highly likely that the problem will become greater, rather than lessening. (Downie and Calman, 1987, p.214) For nurses, like myself, working in the clinical setting it is becoming increasingly difficult to determine the point at which a "good "death can be achieved.

The increasing uncertainty surrounding the moment of death is leading the pro-euthanasia lobby to call for the legislation of active euthanasia. That call is not only being resisted by religious organisations, who view it as being morally wrong, but also by the General Medical Council and the Royal College of Nursing. Perhaps, as Bakewell (1993) suggests, "rather than dispairing about a moral vacuum, we should accept that society`s values are changing." Yet are values really changing ? My own long nursing experience tends to question this statement.

In the earlier part of this century it was acceptable practice for the community midwife to "let nature take its course" and leave the severely disabled baby to die. Similarly, in my early years of nursing on the geriatric wards of the late 1960`s, it was acceptable procedure to give large and regular doses of morphine elixir to patients who were deemed to have "had enough", irrespective of whether they were experienceing any pain. This procedure was still carried out as recently as 1980 when my own father-in-law was dying. In fact, when the treatment was questioned the family were told by one empathic nurse that, had my father-in-law been an animal, they would have allowed him to be put out of his misery a lot sooner.

In many cases, these practices did indeed achieve a "good death" for many patients in our care. Yet, these "treatments" were often decided upon without consultation as to the wishes of either the patient or her/his family. This paternalistic attitude on the part of health professionals, and its ready acceptance by patients and their relatives, did in fact lead to abuses taking place. We often talk of the old days when a failure to treat the "old man`s friend" led to a peaceful and timely death. Yet, we often fail to recall that this very pneumonia was often induced by such practices as the needless administration of morphine elixir and its resultant effect upon respiration.

It is partly my own personal experience that leads me to question the possible legalisation of active euthanasia. It is also the possible reason why I have focused a major part of my study more on the potential difficulties that any legislation of active euthanasia might bring into the clinical setting, particularly in relation to the elderly, the severely disabled, and all those patients who are not competent to speak for themselves. Because of the abuses that I personally witnessed in these earlier practices with regard to the elderly, I am quite happy that such practices would not be so readily accepted today.

Yet, I also accept that these changes in policy have also meant that, for many of those who wish it, a gentle and easy death is now actually being denied. For me personally, the difficulty with active euthanasia arises because, although I feel strongly that I have a responsibity to take those actions necessary to comply with the wishes of the elderly patients in my care, I also have a responsibility to ensure that those same patient's decisions are fully informed and made freely. I think there is a delicate balance to be struck between, on the one hand, carrying out the wishes of individual competent patients whilst, at the same time, protecting the interests of the vulnerable.

These difficulties are also compounded by both the extension of the nurse's role and the changes in patients' expectations regarding their own health-care. In the thirty years that have passed since I began my own nurse-training, I have experienced an increasing role change. Long gone are the days where the sole duty of the nurse in clinical practice was to work at the bedside and act upon decisions made by the doctor. The role of the nurse has now extended to a point where, today, each nurse has had to become an autonomous professional decision-maker in her/his own right.

Increasing autonomy means that many of the clinical decisions that might be made today, including those that might determine whether a patient should live or die, require nurses to be able to think in ethical and legal terms as they are now, more than ever, responsible for their own practice. Whilst it can be accepted that the overall responsibility might always remain with the medical professional in charge, the nurse is now legally accountable for her/his own participation in any decision made or treatment administered. In order to be able to exercise that accountability, nurses need to be sufficiently knowledgeable about all the relevant ethical and legal dimensions of patient-care.

During the same period there have also been changes in the way that patients view their own level of participation in decision-making related to health and illness. Just as nurses have become increasingly autonomous in their professional practice, so patients have become increasingly automonous in their own health-care decisions. Decision-making has become a team exercise, with the patient (and/or relatives) being fully participating members of that team. Patients, particularly younger patients, are less likely to behave with deference towards health professionals, and now expect to be given all the necessary details required for them to make a fully informed choice about their particular treatment and possible prognosis

There is no current issue within clinical nursing practice that has been more affected by these changes than the issue of active euthanasia. Since the beginning of this study, the Royal College of Nursing has highlighted the increasing need for a broader theoretical knowledge-base through which nurses can be enabled to make their ethical decisions. At the same time, organisations who represent the interests of patients, such as the pro-euthanasia lobby, have also increased their demands for the "rights" of the individual patient to be fully-implemented. With regard to active euthanasia this means the right to

self-determination about if, when and how to die.

For active euthanasia to ever become a realistic possibility would require, not only a high degree of sound ethical decision-making on the part of the professionals involved, but also, a high level of certainty that each individual patient has been able to make a fully-informed choice in the matter, without being subject to external pressures. These criteria become even more important, as do the problems, in a situation where the patient is incompetent to make such a decision for her/himself and a third party becomes involved.

The purpose of this study has been to make an examination of the problems and possibilities of active euthanasia in the clinical nursing setting. In doing so, it has also been necessary to make an additional examination of the issues raised by the euthanasia debate, in relation to both continuing professional practice and the education of future cohorts of nursing students. Education is a particularly important issue in this debate because, although each individual nurse's inherent moral values and beliefs underpin her/his own professional practice, the way in which nurses are trained and socialised into the profession can also determine the way in which they make

their ethical decisions.

Although the nurses trained more recently have been given a good grounding in the ethical and legal issues that arise in nursing practice, their training lays less emphasis upon clinical experience. These nurses need time to gain a greater experience of the variety of complex issues that can arise in a day-to-day ward setting. The textbooks can so often paint a black and white picture of the decision-making process. Those of us who have been qualified for much longer, (where the emphasis of training lay towards the more practical elements of nursing) may not always be fully in touch with all the theoretical aspects of these issues. We need time to assimilate this new knowledge with our long-term practical experience.

As has already been mentioned, euthanasia was first described as a "gentle and easy" death, and this definition is still used in the modern dictionary even though the meaning of the term has actually changed twice. Euthanasia may, to some, appear to be a straightforward way of resolving the difficulties that have arisen concerning the end of life. Yet, I would question that active euthanasia could ever become an easy or gentle way forward for those involved in the decision-making process.

No one person can ever truly know what they, themself, or another person, would really want in any given situation, particularly when that individual is unable to speak for themselves. As already mentioned in earlier chapters, several young coma patients who had previously expressed a wish to die, were very relieved to later wake up and find that those wishes had not been complied with.

I have often heard frail elderly and terminally ill patients repeatedly expressing a wish for death, only to see them have a total change of heart when their needs are being met more fully ie; when they are no longer lonely or their pain has been satisfactorily controlled. This is why I have to agree with Dame Cecily Saunders (1971, cited in Lamb, 1988, p.96) and Duncan Vere (1971, cited in Martin, 1995, p.29) when they say that good palliative care can often remove the need for euthanasia. However, I do accept that there are certain cases where active euthanasia is possibly a kinder option. In many of these cases, the decisions made by health professionals are already being upheld through the current legal process.

My own strong feeling is that, should we reach a point where active euthanasia is legalised, for the safety of all concerned the decision-making process must remain in the

hands of the legal system. Those involved with the daily care of the patient may be too close to hold a truly objective opinion.

In this country, to date, active euthanasia is illegal. Therefore, it is not yet possible to make a full assessment as to the validity of the potential problems already discussed earlier. However, there is another area of health-care where legislation has already taken place in which similar ethical dilemmas can arise. ie; that of reproductive medicine. In vitro fertilisation (IVF) has been legal in this country for some time and there are already ethical and legal difficulties regarding the criteria by which it is decided that patients should (or should not) be treated, and, as to the treatments that lie within the guidelines.

The similarities were highlighted for me when I watched a recent episode of the BBC television programme, Making Babies, (BBC1, Thursday, 16th. May, 1996, 9.50pm) in which the consultant, Professor Robert Winston, wished to provide in vitro fertilisation treatment for a woman who was HIV positive. His team of doctors and nurses disagreed with this proposed treatment because hey felt strongly that there would be possible far-reaching implications for the potential child. Despite the team's unanimous objection, Professor Winston subsequently managed to convince two other collegues to help him carry out

the treatment that he personally believed it to be ethical. The team felt as though their feelings on the matter were disregarded and Professor Winston felt betrayed.

Although I would personally agree with the serious reservations expressed by the team members, I am sure that other nurses and doctors would agree with Professor Winston. I believe that the type of disagreement that arose in this case could quite easily arise in a case of euthanasia should it be legalised. Euthanasia, like IVF, is an area of clinical practice where there are many very difficult and emotive issues to be considered. Here too, there could be many occasions where professionals come into conflict about what is the ethical thing to do.

This is why I believe that active euthanasia will not prove to be the straightforward option that many people believe it to be. Every case is different and every individual case must be evaluated individually. Whilst I accept that there are certain cases where euthanasia is a valid option, I would be against legislation at present.

We need to become more familiar with the ethical and legal issues surrounding active euthanasia and where, as nurses,

our responsibilities would begin and end. We also need time to evaulate fully the effects of the Australian legislation and the Dutch experience on those in clinical medical and nursing practice . We must also examine alternative options, such as an increase in good palliative care. Although we have to respect the feelings of those who would wish to end their lives in this way, we also have a moral responsibility to protect the interests of those who would not. Therefore, before we take such an important (and probably irreversible) moral leap we need to be sure it is the only way forward.

APPENDIX A

THE HIPPCRATIC OATH

APPENDIX B

SPECIMEN LIVING WILL

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